| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

## Filing at a Glance

Company: The Union Labor Life Insurance Company

| | | |
|---|---|---|
| Product Name: ULL-HIP-1010 | SERFF Tr Num: ULCC-126925423 | State: Arkansas |
| TOI: H14I Individual Health - Hospital Indemnity | SERFF Status: Closed-Approved-Closed | State Tr Num: 47427 |
| Sub-TOI: H14I.000 Health - Hospital Indemnity | Co Tr Num: ULL-HIP-1010 | State Status: Approved-Closed |
| Filing Type: Form/Rate | | Reviewer(s): Rosalind Minor |
| | Authors: Karen Whitham, Carla Wallace | Disposition Date: 12/30/2010 |
| | Date Submitted: 12/01/2010 | Disposition Status: Approved-Closed |
| Implementation Date Requested: On Approval | | Implementation Date: |

State Filing Description:

## General Information

| | |
|---|---|
| Project Name: individual supplemental hospital indemnity insurance polic | Status of Filing in Domicile: Pending |
| Project Number: | Date Approved in Domicile: |
| Requested Filing Mode: Review & Approval | Domicile Status Comments: |
| Explanation for Combination/Other: | Market Type: Individual |
| Submission Type: New Submission | Individual Market Type: |
| Overall Rate Impact: | Filing Status Changed: 12/30/2010 |
| | State Status Changed: 12/30/2010 |
| Deemer Date: | Created By: Carla Wallace |
| Submitted By: Carla Wallace | Corresponding Filing Tracking Number: |

Filing Description:

Re: NEW INDIVIDUAL INSURANCE POLICY FORM FILING
Supplemental Hospital Indemnity Insurance Policy, ULL-HIP-1010
Wellness Benefit Rider, ULLR-WELL-1010
Ambulance Benefit Rider, ULLR-AMB-1010
Outpatient Surgery Benefit Rider, ULLR-SURG-1010
Critical Event Benefit Rider, ULLR-CRIT-1010
Enrollment Form, ULLA-HIP-1010

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

The Union Labor Life Insurance Company
NAIC: 781-69744 FEIN: 13-1423090

Dear Sir or Madam:

Please find enclosed the above referenced individual supplemental hospital indemnity insurance policy forms for your review and approval. These forms are new and do not replace any forms currently on file with your office.

This product will be marketed through direct mail response and available for purchase on our website. Enrollment is on a guaranteed issue basis. Issue ages are ages 18 to 64.

Supplemental Hospital Indemnity Insurance Policy, ULL-HIP-1010: The policy pays a daily hospital indemnity benefit for an injury or sickness as defined in the policy that results in hospital confinement as an inpatient. Hospital confinement must begin while the insured is covered under the policy. Daily hospital indemnity benefit amounts are payable from the first day of hospital confinement and will continue for as long as the insured is hospital confined for the injury or sickness, up to a maximum shown on the Schedule.

Wellness Benefit Rider, ULLR-WELL-1010: This benefit rider is an optional supplemental health benefit rider that pays a lump sum indemnity benefit to the insured for preventive care office visits to a health care provider. Preventive care office visits include eye examinations performed by an optometrist or ophthalmologist, dental examinations, and preventive health services as defined by Section 2713 (29 CFR 2590.715-2713) of the Patient Protection and Affordable Care Act (PPACA).

Ambulance Benefit Rider, ULLR-AMB-1010: This benefit rider is an optional supplemental health benefit rider that pays a lump sum indemnity benefit to the insured if a licensed surface or air ambulance service transports the insured to or from a hospital where the insured is confined as an inpatient due to sickness or injury as defined in the policy, including transportation from one medical facility to another when necessary. Any ambulance service must be necessary to protect the insured's health and safety when other reasonable and customary travel methods are not available. The ambulance service must be provided while the policy and this benefit rider are in-force.

 
Outpatient Benefit Surgery Rider, ULLR-SURG-1010: This benefit rider is an optional supplemental health benefit rider that pays a daily indemnity benefit if the insured receives outpatient surgery as a result of an injury or sickness as defined in the policy. The outpatient surgery must be medically necessary, recommended by a physician, and performed in an emergency room, trauma center, urgent care center, hospital outpatient facility or free standing surgical facility. Cataract surgery can be performed in a physician's office. The insured must be covered under the policy and this benefit rider at the time of the outpatient surgery, and the insured must not be admitted to a hospital as an inpatient as a result of that same injury or sickness.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

No benefit is paid for a Pre-Existing Condition or any outpatient treatments or surgeries for which the principal function is injections, dental procedures, dermatology procedures, sutures removal, or chemotherapy or radiological procedures.

Critical Event Benefit Rider, ULLR-CRIT-1010: This benefit rider is an optional supplemental health benefit rider that pays a lump sum indemnity benefit if the insured experiences a diagnosis of cancer, a stroke, a heart attack, the onset of irreversible paralysis, or a hospital confinement due to a workplace accident. The insured must be covered under the policy and this benefit rider at the time of the critical event. Each critical event benefit can be claimed only once by an insured.

All benefits except the optional Wellness Benefit reduce by 50% upon attainment of age 70. Under the family plan, benefits for covered Dependent Children are 50% of the benefits for the Primary Insured, except the Wellness benefit.

The enrollment form and the optional supplemental health benefit riders may be used with this individual hospital indemnity insurance policy or any other health insurance policy we may offer that has been approved for use by your Department.

To the best of our knowledge and belief, these forms comply with all applicable state insurance laws and regulations.

All forms are in final print format.

If you have any questions, please let us know.

Sincerely,

Carla W. Wallace, MA
Senior Compliance Analyst
Plan Development

SOLUTIONS FOR THE UNION WORKPLACE

8403 Colesville Road
Silver Spring, MD 20910
202.962.2901 phone
202.682.6713 fax
cwallace@ullico.com

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

www.ullico.com

## Company and Contact

**Filing Contact Information**

| | |
|---|---|
| Carla Wallace, Compliance Analyst | cwallace@ullico.com |
| 8403 Colesville Rd | 202-962-2901 [Phone] |
| Silver Spring, MD 20910 | |

**Filing Company Information**

| | | |
|---|---|---|
| The Union Labor Life Insurance Company | CoCode: 69744 | State of Domicile: Maryland |
| 8403 Colesville Road | Group Code: 781 | Company Type: Life and Heallth |
| Silver Spring, MD 20910 | Group Name: | State ID Number: |
| (202) 682-0900 ext. [Phone] | FEIN Number: 13-1423090 | |

---

## Filing Fees

| | |
|---|---|
| Fee Required? | Yes |
| Fee Amount: | $750.00 |
| Retaliatory? | Yes |
| Fee Explanation: | 6 forms filed @ $125.00 = $750.00 |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|---|---|---|
| The Union Labor Life Insurance Company | $750.00 | 12/01/2010 | 42499838 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

# Correspondence Summary

### Dispositions

| Status | Created By | Created On | Date Submitted |
|---|---|---|---|
| Approved-Closed | Rosalind Minor | 12/30/2010 | 12/30/2010 |

### Objection Letters and Response Letters

| Objection Letters | | | | Response Letters | | |
|---|---|---|---|---|---|---|
| **Status** | **Created By** | **Created On** | **Date Submitted** | **Responded By** | **Created On** | **Date Submitted** |
| Pending Industry Response | Rosalind Minor | 12/03/2010 | 12/03/2010 | Carla Wallace | 12/08/2010 | 12/08/2010 |

### Filing Notes

| Subject | Note Type | Created By | Created On | Date Submitted |
|---|---|---|---|---|
| Right to Adjust Premium Rate Section | Note To Reviewer | Carla Wallace | 12/30/2010 | 12/30/2010 |
| Right to Adjust Premium Rate Section | Note To Reviewer | Carla Wallace | 12/20/2010 | 12/20/2010 |
| Your Note to Reviewer of 12/12/10 | Note To Filer | Rosalind Minor | 12/16/2010 | 12/16/2010 |
| Right to adjust.... | Note To Reviewer | Carla Wallace | 12/12/2010 | 12/12/2010 |
| Right to Adjust Premium Rate | Note To Filer | Rosalind Minor | 12/09/2010 | 12/09/2010 |
| ULL-HIP-1010 AR Response. | Note To Reviewer | Carla Wallace | 12/08/2010 | 12/08/2010 |
| Your response on 12/8/10 | Note To Filer | Rosalind Minor | 12/08/2010 | 12/08/2010 |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

# Disposition

Disposition Date: 12/30/2010
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---|---|---|---|
| **Supporting Document** | Flesch Certification | Approved-Closed | Yes |
| **Supporting Document** | Application | Approved-Closed | Yes |
| **Supporting Document** | Health - Actuarial Justification | Approved-Closed | No |
| **Supporting Document** | Outline of Coverage | Approved-Closed | Yes |
| **Form** | Wellness Benefit Rider | Approved-Closed | Yes |
| **Form** | Ambulance Benefit Rider | Approved-Closed | Yes |
| **Form** | Outpatient Surgery Benefit Rider | Approved-Closed | Yes |
| **Form** | Critical Event Benefit Rider | Approved-Closed | Yes |
| **Form** | Enrollment Form | Approved-Closed | Yes |
| **Form** | Supplemental Hospital Indemnity Insurance Policy | Approved-Closed | Yes |

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

# Objection Letter

| | |
|---|---|
| Objection Letter Status | Pending Industry Response |
| Objection Letter Date | 12/03/2010 |
| Submitted Date | 12/03/2010 |
| Respond By Date | |

Dear Carla Wallace,

This will acknowledge receipt of the captioned filing.

Objection 1

- Supplemental Hospital Indemnity Insurance Policy, ULL-HIP-1010 AR (Form)

Comment:

Coverage for newborn infants must be for at least 90 days as outlined under ACA 23-79-129.

Objection 2

- Supplemental Hospital Indemnity Insurance Policy, ULL-HIP-1010 AR (Form)

Comment:

Please refer to the 60-day period for coverage for minors for whom the insured has filed a petition to adopt - ACA 23-79-137.

Objection 3

- Supplemental Hospital Indemnity Insurance Policy, ULL-HIP-1010 AR (Form)

Comment:

With respect to the provision for Right to Adjust Premium Rates, it is stated that….."we may change rates, by class, on any premium due date. We will provide written notice at lease 31 days before the date of change.

It has been our Departmental policy for years that rate increases will not be given prior to the first annual anniversary date of any policy and after the first annual anniversary date of any policy, increases will not be given more frequently than once in a twelve (12) month period.

All increases in rates, other than a change in age or an individual moving to another geographical area, must be submitted to our Department for approval.

Objection 4

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

- Supplemental Hospital Indemnity Insurance Policy, ULL-HIP-1010 AR (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured as outlined under ACA 23-85-134.

Objection 5

- Supplemental Hospital Indemnity Insurance Policy, ULL-HIP-1010 AR (Form)

Comment:

Coverage must be continued for handicapped dependents, plus there can be not time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

# Response Letter

| | |
|---|---|
| Response Letter Status | Submitted to State |
| Response Letter Date | 12/08/2010 |
| Submitted Date | 12/08/2010 |

Dear Rosalind Minor,

**Comments:**
Good Morning,

Per your request,

## Response 1

Comments: Form ULL-HIP-1010 AR has been revised to reflect Coverage for newborn infants outlined under ACA 23-79-129.

**Related Objection 1**

Applies To:

- Supplemental Hospital Indemnity Insurance Policy, ULL-HIP-1010 AR (Form)

Comment:

Coverage for newborn infants must be for at least 90 days as outlined under ACA 23-79-129.

**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

## Response 2

Comments: Form ULL-HIP-1010 AR has been revised to reflect 60-day period for coverage for minors for whom the insured has filed a petition to adopt - ACA 23-79-137.

**Related Objection 1**

Applies To:

- Supplemental Hospital Indemnity Insurance Policy, ULL-HIP-1010 AR (Form)

Comment:

Please refer to the 60-day period for coverage for minors for whom the insured has filed a petition to adopt - ACA 23-79-137.

**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

## Response 3

Comments: Form ULL-HIP-1010 AR has been revised.

**Related Objection 1**

Applies To:

- Supplemental Hospital Indemnity Insurance Policy, ULL-HIP-1010 AR (Form)

Comment:

With respect to the provision for Right to Adjust Premium Rates, it is stated that….."we may change rates, by class, on any premium due date. We will provide written notice at lease 31 days before the date of change.

It has been our Departmental policy for years that rate increases will not be given prior to the first annual anniversary date of any policy and after the first annual anniversary date of any policy, increases will not be given more frequently than once in a twelve (12) month period.

All increases in rates, other than a change in age or an individual moving to another geographical area, must be submitted to our Department for approval.

**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

## Response 4

Comments: Form ULL-HIP-1010 AR has been revised to reflect the provision for the refund of unearned premium in the event of death of the insured as outlined under ACA 23-85-134.

**Related Objection 1**

Applies To:

- Supplemental Hospital Indemnity Insurance Policy, ULL-HIP-1010 AR (Form)

Comment:

There needs to be a provision for the refund of unearned premium in the event of death of the insured as outlined under ACA 23-85-134.

**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

## Response 5

Comments: Form ULL-HIP-1010 AR has been revised to reflect continued coverage for handicapped dependents as outlined under ACA 23-85-131(b) and Bulletin 14-81.

**Related Objection 1**

Applies To:

- Supplemental Hospital Indemnity Insurance Policy, ULL-HIP-1010 AR (Form)

Comment:

Coverage must be continued for handicapped dependents, plus there can be not time limit set for furnishing proof

of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

**Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

If you have questions please contact me at 202-962-2901 or cwallace@ullico.com

Sincerely,
Carla Wallace, Karen Whitham

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

**Note To Reviewer**

**Created By:**
Carla Wallace on 12/30/2010 09:22 AM
**Last Edited By:**
Rosalind Minor
**Submitted On:**
12/30/2010 12:13 PM
**Subject:**
Right to Adjust Premium Rate Section
**Comments:**
Per our conversation this morning, The right to Adjust Premium Rate section has been hghlighted to reflect the correction regarding the deletion of the second sentence. The revised page has beenattached for your approval.

I can be reached at 202-962-2901 or cwallace@ullico.com

Thank you,

Carla Wallace

# The Union Labor Life Insurance Company

**("We, Us, Our, the Company")**

**[Administrative Office: 8403 Colesville Road, Silver Spring, MD 20910**
**Executive Office: 1625 Eye Street N.W., Washington DC 20006]**

## SUPPLEMENTAL HOSPITAL INDEMNITY INSURANCE POLICY

This insurance Policy pays benefits in the event of Hospital Confinements due to Sickness and Injury. The Policy is a legal contract. You rely on Us to honor its terms. We depend on Your payment of premium when due. This Policy is issued to the Policyholder. The Policy is issued in consideration of a completed enrollment form and timely payment of the premiums when due. Any payments are subject to all the terms and conditions of this Policy.

This Policy takes effect at 12:01 A.M. Standard Time at Your address on the Policy Effective Date shown on the Policy Schedule. After the first 12 month period, this Policy will automatically renew from year to year for additional 12 month periods subject to the Policy Termination provision. .

**60 Day Right to Examine the Policy:** If You are not satisfied, for any reason, You may return the Policy within 60 days of the date received. When returned, the Policy will be void from the beginning, and any premiums paid will be refunded. The Policy must be returned to Us at Our Administrative Office or to Our authorized producer.

**Pre-Existing Condition Limitation:** We will not pay a benefit for a Pre-existing Condition. Expenses for a Pre-Existing Condition will be eligible after the Insured has been covered for twelve consecutive months. The Pre-Existing Condition Limitation will apply to new Covered Dependents or an increase in benefits on the effective date of the change in coverage, but will not apply to coverage already in force.

**Guaranteed Renewable:** We guarantee to renew this Policy subject to the timely payment of premiums when due. No change will be made in the premium rates unless We make a change on all policies of this form in Your state.

**This is not a Medicare Supplement Policy.** If You are eligible for Medicare, please review the Medicare Supplement Buyer's Guide available from Us.

In Witness, this Policy is signed by the officers below.

[officer signature] [officer signature]

**PARTICIPATING**

**BENEFITS REDUCE AT AGE 70**
**[REDUCED BENEFITS FOR COVERED DEPENDENT CHILDREN]**

**TABLE OF CONTENTS**

## SCHEDULE

**Policyholder:** [John Doe]

**Policy Number** [12345]

**Principal Insured:** [John Doe]

**Policy Delivered In:** [state]

**Dependent Spouse/Domestic Partner:**
[Jane Doe]

**Dependent Children:**
[Mary Doe]

**Policy Effective Date:** [January 1, 2011]

**Premium Due Date:** [January 1, 2011]

**Premium:** [$xx.xx quarterly]

Insurance Benefits are determined by this Schedule and the terms of the Policy.

| **Description of Benefits** | **Benefit Amounts and Limits**<br>(Benefits apply to all Insureds unless otherwise noted) |
|---|---|
| **Hospital Confinement Indemnity Benefit** | [$xxx] daily benefit for the first [3] days in a Policy Year<br>[$xxx] daily benefit after the first [3] days in a Policy Year<br>Maximum of [180] days per Policy Year |
| [**Wellness Benefit** | [$xxx] per visit, up to [1 visit] per Policy Year ] |
| [**Emergency Ambulance Benefit** | [$xxx] per ambulance trip, up to [1 payment] per Policy Year] |
| [**Outpatient Surgery Benefit** | [$xxx] Benefit, up to one payment per calendar day] |
| [**Critical Event Indemnity Benefit** | [$xxx] Benefit, up to one payment per category of covered event] |
| **Labor Dispute Waiver of Premium Benefit** | Premium waived for up to one year during participation in a lawful strike or lock-out. Principal Insured only. |

| **Benefit Percentages** | |
|---|---|
| Adults under age 70 | 100% of the Benefit Amounts |
| Adults age 70 and over | 50% of the Benefit Amounts, except as below<br>100% of the Wellness Benefit |
| [Covered Dependent Children: | 50% of the Benefit Amounts<br>100% of the Wellness Benefit ] |
| *[OR]*<br>[Covered Dependent Child: | 100% of the Benefit Amounts] |

**Termination Age:** None

## DEFINITIONS

When used in this Policy the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

**Complications of Pregnancy** (which are considered to be a Sickness under this Policy) means conditions arising during pregnancy whose diagnoses are separate from pregnancy but are unfavorably affected by pregnancy or are caused by pregnancy, such as: (1) infections of the genital or urinary tract; (2) acute nephritis; (3) nephrosis; (4) necrosis of the liver or kidney; (5) hypertension; and (6) similar conditions of comparable severity.

Complications of Pregnancy also includes abnormal maternal conditions directly related to and caused by pregnancy, such as: (1) hemorrhage of pregnancy; (2) rupture of uterus; (3) hydatidiform mole; (4) hyperemesis gravidarum; (5) eclampsia; (6) ectopic pregnancy; (7) non-elective caesarean section; and (8) spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy shall not include: (1) false labor; (2) occasional spotting; (3) physician prescribed rest; (4) morning sickness; or (5) other minor conditions associated with normal pregnancy.

**Confined or Confinement** means the Insured is a registered bed patient in a Hospital and is charged room and board by the facility. He must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. The Confinement must be Medically Necessary for the treatment of the Sickness or Injury.

Confinement does not include treatment received in the outpatient department of the facility.

**Covered Dependent** means any Dependent who is insured.

**Dependent** means: (1) Your lawful spouse (including your Domestic Partner); and (2) Your unmarried child(ren) who are under age 19 (or under age 25 if enrolled as a full-time student in an accredited post secondary school, college, or vocational or technical school). The child(ren) must be primarily dependent on You for support and maintenance.

Newborn children are covered from the moment of birth. Your adopted child is covered from the earlier of: (a) the moment the adoption is recognized as legal by Your home state; or (b) the date coverage is required to start by the laws of Your home state.

A newborn child is a Covered Dependent for 90 days. Coverage then stops unless You: (a) send Us a written request to continue coverage; and (b) pays any required additional premium.

Coverage for adopted minors shall include coverage for any minor under the charge, care, and control of the insured whom the insured has filed a petition to adopt. The coverage of the minor shall be the same as provided for other members of the insured's family. Coverage shall begin on the date of the filing of a petition for adoption if the insured applies for coverage within sixty (60) days after the filing of the petition for adoption. However, the coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within sixty (60) days after the birth of the minor. The coverage shall terminate upon the dismissal or denial of a petition for adoption.

An unmarried dependent who is incapable of sustaining employment by reason of mental retardation or physical disability, who became so incapacitated prior to the attainment of the age of nineteen (19) years and who is chiefly dependent upon the policyholder for support and maintenance, shall not terminate but coverage shall continue so long as the contract remains in force and so long as the dependent remains in such condition.

**Domestic Partner** means the domestic partner of the Principal Insured, for whom we have been furnished and accepted proof:

a. of financial interdependence such as joint bank accounts, joint credit cards, jointly owned property and beneficiary designations for life insurance or pension plans;
b. of co-habitation;
c. of a prior relationship of a least 6 months, with an expectation of a future commitment;

d. of attainment of the age of majority;
e. that neither the Principal Insured or the domestic partner are legally married;
f. that the Principal Insured is not related by blood to the domestic partner; and
g. of filing as domestic partners, if the Principal Insured is a resident of a city, municipality or other governing jurisdiction that allows for filing as domestic partners.

The Principal Insured is responsible for notifying us upon dissolution of the domestic partnership and of any change in the status of the proof furnished to us evidencing the domestic partnership.

**Hospital** means an institution which meets all of the following requirements: (1) it must be operated according to law; (2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an Inpatient basis for which a charge is made; (3) it must provide diagnostic and surgical facilities supervised by Physicians; (4) Registered Nurses must be on 24 hour call or duty; and (5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

Except as specifically provided by this Policy or state law, the term Hospital does not include a facility, or part of a facility or Hospital, which is licensed as and providing care primarily as: (1) a rest facility, nursing facility, convalescent facility, or facility for the aged; (2) a chronic or skilled nursing facility, extended care facility, or a rehabilitation facility; or (3) a facility or program for treatment of mental illness, behavioral problems, or alcohol or drug abuse.

**Immediate Family** means Your spouse, Domestic Partner, child(ren), parents, brother(s), sister(s), in-laws or any member of Your household.

**Injury** means bodily Injury caused by an accident. It must be sustained by the Insured while coverage is in force. The Injury must be the direct cause of Loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

**Inpatient** means a registered bed patient Confined in a Hospital.

**Insured** means the Principal Insured and each Covered Dependent.

**Loss** means the Hospital Confinement of an Insured. Loss also means the occurrence of any other event for which benefits are payable under this Policy.

**Medically Necessary** means care, services, supplies, or treatment ordered by a Physician for the diagnosis or treatment of a Sickness or Injury. To be Medically Necessary, the care, services, or supplies must: (1) be appropriate and necessary for the symptoms, diagnosis or treatment, of the Insured's condition, disease, ailment, or Injury; (2) be provided for the diagnosis or direct care of the Insured's medical condition; (3) be in accordance with standards of good medical practice accepted by the organized medical community; (4) not be primarily for the convenience and/or comfort of the Insured, his family, his Physician or another provider of services; and (5) not be experimental or investigational.

In addition, Medically Necessary means care that is reasonable, necessary, and not custodial. Care is considered to be custodial when its primary purpose is to meet activities of daily living that could be met by persons other than Physicians and Nurses.

**Mental Disease or Disorder** means neurosis; psychoneurosis; psychopathy; psychosis; or mental or emotional disease or disorder of any kind without a demonstrable organic cause.

**Nurse** means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). A Nurse may not be You or a member of Your Immediate Family.

**Physician** means a licensed physician or other practitioner who is practicing within the scope of his license for the service or treatment provided. Neither You nor any member of Your Immediate Family will be considered a Physician.

**Policy Year** means each continuous 12-month period the policy is in force beginning from the Policy Effective Date.

**Pre-Existing Condition** means a condition for which medical: advice; diagnosis; care; or treatment was recommended by or received from a Physician during the six-month period immediately prior to the Insured's Effective Date of coverage. Pregnancy is not a Pre-Existing Condition.

**Premium** means the payment made for coverage.

**Principal Insured** means the person who enrolled for coverage and who is named as the "Principal Insured."

**Sickness** means an illness, disease, or physical condition which first manifests while the Insured is covered under the Policy. It also includes Complications of Pregnancy.

**We, Our and Us** means The Union Labor Life Insurance Company.

**You, Your, and Yours** means the Principal Insured.

## EFFECTIVE DATE OF INSURANCE

**Principal Insured:** The coverage takes effect at 12:01 A.M., Standard Time, at Your home on the Effective Date. Before coverage takes effect, You must enroll and pay the required premium. If no premium is required at time of enrollment, the first premium is due within 21 days of the Effective Date. Failure to pay the premium will void coverage from the Effective Date and no benefits will be paid.

**Dependent:** You may insure any Dependent on the later of: (a) the Effective Date; or (2) the date a Dependent is acquired.

If an Insured is Confined in a Hospital or an institution which provides medical care and treatment on the date his insurance would otherwise become effective, he will be insured the day following formal Hospital or institution discharge.

**Changes in Coverage:** To add a Dependent, You must: (a) send Us a written request; and (b) pay any required additional premium.

The effective date for any additional Dependents will be the date shown on Our endorsement or change form.

If a new eligible Dependent is added or if the change request increases the amount of coverage or adds new benefits, the Effective Date of insurance will be deferred if the Dependent is Confined in a Hospital or an institution which provides medical care and treatment on the date the insurance would otherwise become effective. The change will be effective the day following formal discharge from the Hospital or institution. This does apply to newborn children.

## HOSPITAL CONFINEMENT INDEMNITY BENEFIT

We will pay the benefit shown on the Schedule when We receive satisfactory proof of Loss that, as a result of a covered Injury or Sickness as defined in the Policy, the Insured is Confined in a Hospital as an Inpatient. The Confinement must begin while the Insured is covered under this Policy.

Benefits will be paid from the first day of Hospital Confinement and will continue for as long as the Insured is Confined for such Injury or Sickness, up to the maximum shown on the Schedule.

## LABOR DISPUTE WAIVER OF PREMIUM BENEFIT

We will waive premiums for the policy and any attached riders if the Principal Insured is Actively at Work and:
1. Participating in a lawful strike authorized by the Principal Insured's labor union; or
2. Locked-out of his or her place of employment as a result of a labor dispute between the Principal Insured's labor union and employer.

The premium to be waived for the premium period is:
1. The premium amount shown in the Schedule; plus
2. The cost for additional benefits provided by a rider, if any.

"Actively at Work" means the Principal Insured is performing all the regular duties of his or her occupation at the time the strike or lock-out begins.

This benefit begins on the next premium due date after the 30-day period immediately following the start of the strike or lock-out. We must receive at Our Administrative Office written notice and satisfactory proof to Us of the strike or lock-out. We must receive such notice and proof before benefits begin. This rider must be in force before the date the strike or lock-out begins. The Principal Insured must be a member in good standing. The Principal Insured must also be Actively at Work with the employer at the beginning of the strike. To receive benefits under this rider, satisfactory proof of the status of the strike or lock-out must be given Us when and as often as We may reasonably require, but in no event less than every 30 days.

We will stop providing benefits if proof of status is not provided as required. We must also be notified as soon as:
1. The strike or lock-out is resolved;
2. The Principal Insured returns to work or is offered the opportunity to return to work for his or her employer; or
3. The Principal Insured's employment is terminated.

Benefits end and premiums will again begin on the earliest of the following dates:
1. One year from the date benefits under this Rider began;
2. The next premium due date following the date the strike or lock-out is resolved;
3. The next premium due date following the date the Principal Insured returns to work or is offered the opportunity to return to work for his or her employer; or
4. The next premium due date following the date the Principal Insured's employment is terminated.

## EXCLUSIONS

Benefits will not be paid under this Policy for Hospital Confinements caused by, resulting from or contributed to by:
1. Injuries resulting from active military service; any active participation in a riot; armed conflict, or insurrection;
2. Declared or undeclared war or any act of war;
3. The use or taking of any narcotic, barbiturate, or any other drug by the Insured unless administered in a therapeutic dosage as prescribed by a Physician;
4. An Injury that occurs while the Insured has a blood alcohol level of .08 (by weight or volume) or higher;
5. Treatment of a Mental Disease or Disorder, alcoholism or drug addiction;
6. Pregnancy or childbirth (Complications of Pregnancy are covered on the same basis as Sickness);
7. Any Confinement rendered in a Hospital which does not comply with the Hospital definition (e.g. nursing facility, convalescent facility, or rehabilitation facility, etc. are not covered);
8. Any rehabilitative care in a Hospital;
9. Suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane;
10. Expenses incurred or care received outside of the United States beyond a period of 14 days of Hospital Confinement; or
11. An Injury that occurs while the Insured is committing an assault or felony.

## TERMINATION OF INSURANCE

If premium is not paid by the due date or during the 31 day Grace Period, coverage for all Insureds stops at the end of the Grace Period.

Dependent spouse or Domestic Partner coverage will end on the premium due date after a change in marital status. The Dependent spouse or Domestic Partner may apply for his own Policy. We must receive a written request within 60 days of the change in marital status. The spouse or Domestic Partner then pays the premium for individual coverage.

A Dependent child's coverage will end upon the earliest of the following: (a) marriage; (b) cessation of eligibility as a Dependent; or (c) attainment of age 19 (or age 25 if enrolled as a full-time student in an accredited post secondary school, college, or vocational or technical school).

If one of these events occurs, the Covered Dependent child may apply for his own Policy. We must receive a written request within 60 days of the date coverage stops. The child then pays the premium for individual coverage.

**Principal Insured's Death:** If coverage terminates due to Your death, the Covered Dependent spouse or Domestic Partner, if any, becomes the Principal Insured. Coverage may continue for any Dependent Children covered at the time of Your death. No evidence of insurability is needed. The spouse or Domestic Partner must provide Us with written notice of Your death within 60 days after the date of death. Premiums will be adjusted if necessary.

However, if there is no surviving spouse or Domestic Partner at the time of Your death, coverage for Dependent Children will end.

## EXTENSION OF BENEFITS

If an Insured's coverage terminates, for any reason except non-payment of premium, while the Insured is Hospital Confined, the Insured will be eligible for benefits for that Hospital Confinement just as if coverage had not ended.

No additional premium is needed for the extended benefit period after termination of coverage.

## HOW TO PAY THE PREMIUM

**Premium Payments:** You keep coverage in force by paying the premiums. The first premium is due prior to the Effective Date. After that, premiums are due on the first day of each renewal period.

**Grace Period:** You have a Grace Period of 31 days after the due date to pay the premium. The coverage stays in force if premium is paid during this Grace Period. If premium is not paid within this Grace Period, his coverage will lapse.

**Reinstatement of Coverage:** If an Insured's premium is not paid before the Grace Period ends, his coverage will lapse. Later acceptance of premium (by Us or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate his coverage. We may require an application for reinstatement. If so, the Insured will be given a conditional receipt for the premium. When the application is approved, the coverage will be reinstated as of the approval date. Lacking such approval, the coverage will be reinstated on the 45th day after the date of the conditional receipt unless We have previously written the Insured of Our disapproval. The reinstatement will cover only Loss due to an Injury sustained after the date of reinstatement; or to a Sickness that begins more than 10 days from the reinstatement date. In all other respects Our rights and the rights of the Insured will remain the same.

**Unpaid Premium:** When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

**Right To Adjust Premium Rates:** We may change rates, by class, on any premium due date. We will provide written notice at least 31 days before the date of change. *Rate increases will not be given prior to the first annual anniversary date of the policy and after the first annual anniversary date of the policy.*

All increases in rates, other than a change in age or an individual moving to another geographical area, must be submitted to our Department for approval.

## HOW TO FILE A CLAIM

**Notice of Claim:** Written notice of claim, satisfactory to Us, must be given within 30 days after a covered Loss starts, or as soon as reasonably possible. The notice must include the Insured's name and the Policy Number.

**Claim Forms:** When We receive a notice of claim, We will send forms for filing Proof of Loss. If the forms are not sent within fifteen days, the Insured should submit a written statement of the nature and extent of the Loss. This statement should be submitted within the time noted for Proof of Loss.

**Proof of Loss:** Written Proof of Loss, satisfactory to Us, must be given within 90 days after the Loss or as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless it was legally impossible to do so.

## CLAIM PAYMENT

**Payment of Claims:** Claims for benefits provided by this Policy will be paid as soon as written Proof of Loss is received. All benefits are paid directly to the Insured, unless directed otherwise. Any benefits unpaid at the Insured's death will be paid to his estate, except that We may pay benefits, up to $1,000 in benefits, to any relative by blood or marriage who We consider to be entitled to the benefits. Any payments We make in good faith will fully discharge Our liability.

**Right to Examine Hospital or Physician Records:** We may, at Our own expense, examine an Insured's Hospital and Physician records as often as necessary while a claim is pending.

**Physical Examination:** At Our expense, We have the right to have the Insured examined as often as reasonably necessary while a claim is pending. We will pay for these expenses.

## OTHER IMPORTANT INFORMATION

**Conformity to Law:** Any provision of this Policy which is in conflict with the laws of the state where the Policy is issued is amended to conform to the laws of that state.

**Dividends:** This is a Participating Policy. While it is in force, it is eligible for dividends as determined by Our Board of Directors. Any dividend will be paid in cash or used to reduce the next premium due.

**Unearned Premium:** Upon the death of an insured, the proceeds payable to the insured or his estate under the policy of individual accident and health insurance, delivered or issued for delivery in this state after June 17, 1981, shall include premiums paid, for accident and health insurance coverage for the insured, for any period beyond the end of the policy month in which the death occurred. Unearned premiums shall be paid in lump sum on a date no later than (30) days after the proof of the insured's death has been furnished to the insurer.

**Entire Contract:** This Policy, including the endorsements and attached papers, if any, is the entire contract between the parties. No change in this Policy will be effective until approved by one of Our officers. Such approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

**Legal Actions:** No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action shall be brought after 3 years from the time written Proof of Loss is required.

**Misstatement of Age:** If the Insured's age has been misstated in the enrollment form for insurance, the benefits payable will be those which the premiums paid would have purchased based upon his correct age. There will be an equitable adjustment of premium.

**Other Insurance in this Company:** If You are covered under more than one similar policy or group certificate issued by Us, we may limit the benefits available under the additional policies or certificates. We will return any excess premiums paid under the other policies or group certificates for the same period of coverage.

**Representations:** In the absence of fraud, all statements made by the policyholder or an insured person shall be deemed representations and not warranties, and no statement made for the purpose of effecting insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary.

**Time Limit on Certain Defenses:** No claim for a Loss incurred or commencing after twenty-four months from the date the Insured becomes covered will be reduced or denied on the ground that an Injury or Sickness had existed prior to the Effective Date of the Insured's coverage.

**LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

**DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do ~~not~~ not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

**NOTICE OF**
**THE ARKANSAS LIFE AND HEALTH**
**INSURANCE GUARANTY ASSOCIATION ACT**

The Arkansas Life and Health Insurance Guaranty Association Act (the "Act") provides protection, subject to certain limitations and exclusions, against loss under life and health insurance policies and annuity contracts issued by insolvent insurers licensed in this state. Some limitations and exclusions apply; some are listed below.

This notice is provided to you only to make you aware of the existence of the limited protection under the Act. It confers no rights to any policyholder or contract holder not provided under the Act. It does not change or vary any exclusion or limitation contained in the Act. Specific reference must be made to the Act to determine whether any particular policy or contract is covered, the amount of any coverage which may be available, and applicable limitations or exclusions.

Some of the limitations and exclusions are as follows:

1. The Act limits the amount the Guaranty Association is obligated to pay: The Association cannot pay more than what the insurer would owe under a policy or contract. Also, for any one insured, the Guaranty Association will pay a maximum of $300,000 no matter how many policies or contracts you have with the same insurer even if they provide different coverages. Within this overall $300,000 limit, the Association will pay a maximum of $300,000 in net cash surrender values, $300,000 in life insurance death benefits, $300,000 in present value of annuities, and $300,000 in disability or health insurance benefits. There is a $1,000,000 limit with respect to any one contract holder for unallocated annuity benefits irrespective of the number of participants in the plan.

2. You are not covered:
   a. If you are not a resident of Arkansas at the time the order of the insurer's insolvency was issued;
   b. Your insurer was not licensed in this state; or,
   c. Your insurer was a self-insured plan, trust or other similar entity, health maintenance organization or other entity excluded under the Act.

3. Obligations not specifically provided in the policy or contract are not covered by the Act. Examples of obligations, which are not covered by the Act, include damages or loss due to misrepresentations of policy benefits, inaccurate solicitation material, unfiled policy documents or endorsements, and extra-contractual damages, penalties and similar damages or claims.

4. Dividends or interest rate yields that do not meet specifications described in the Act are not covered under the Act.

**You should not rely upon coverage under the Act when buying a life or health insurance policy or selecting an insurer, and neither agents nor insurers should use the existence of the Guaranty Association to induce you to purchase a product from them.**

For more information relative to the Act, you may contact:

The Arkansas Life and Health
Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, AR 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

# The Union Labor Life Insurance Company

**("We, Us, Our, the Company")**

**[Administrative Office: 8403 Colesville Road, Silver Spring, MD 20910**
**Executive Office: 1625 Eye Street N.W., Washington DC 20006]**

## SUPPLEMENTAL HOSPITAL INDEMNITY INSURANCE POLICY

This insurance Policy pays benefits in the event of Hospital Confinements due to Sickness and Injury. The Policy is a legal contract. You rely on Us to honor its terms. We depend on Your payment of premium when due. This Policy is issued to the Policyholder. The Policy is issued in consideration of a completed enrollment form and timely payment of the premiums when due. Any payments are subject to all the terms and conditions of this Policy.

This Policy takes effect at 12:01 A.M. Standard Time at Your address on the Policy Effective Date shown on the Policy Schedule. After the first 12 month period, this Policy will automatically renew from year to year for additional 12 month periods subject to the Policy Termination provision. .

**60 Day Right to Examine the Policy:** If You are not satisfied, for any reason, You may return the Policy within 60 days of the date received. When returned, the Policy will be void from the beginning, and any premiums paid will be refunded. The Policy must be returned to Us at Our Administrative Office or to Our authorized producer.

**Pre-Existing Condition Limitation:** We will not pay a benefit for a Pre-existing Condition. Expenses for a Pre-Existing Condition will be eligible after the Insured has been covered for twelve consecutive months. The Pre-Existing Condition Limitation will apply to new Covered Dependents or an increase in benefits on the effective date of the change in coverage, but will not apply to coverage already in force.

**Guaranteed Renewable:** We guarantee to renew this Policy subject to the timely payment of premiums when due. No change will be made in the premium rates unless We make a change on all policies of this form in Your state.

**This is not a Medicare Supplement Policy.** If You are eligible for Medicare, please review the Medicare Supplement Buyer's Guide available from Us.

In Witness, this Policy is signed by the officers below.

[officer signature] [officer signature]

**PARTICIPATING**

**BENEFITS REDUCE AT AGE 70**
**[REDUCED BENEFITS FOR COVERED DEPENDENT CHILDREN]**

**TABLE OF CONTENTS**

## SCHEDULE

**Policyholder:** [John Doe]

**Policy Number** [12345]

**Principal Insured:** [John Doe]

**Policy Delivered In:** [state]

**Dependent Spouse/Domestic Partner:**
[Jane Doe]

**Dependent Children:**
[Mary Doe]

**Policy Effective Date:** [January 1, 2011]

**Premium Due Date:** [January 1, 2011]

**Premium:** [$xx.xx quarterly]

Insurance Benefits are determined by this Schedule and the terms of the Policy.

| **Description of Benefits** | **Benefit Amounts and Limits**<br>(Benefits apply to all Insureds unless otherwise noted) |
|---|---|
| **Hospital Confinement Indemnity Benefit** | [$xxx] daily benefit for the first [3] days in a Policy Year<br>[$xxx] daily benefit after the first [3] days in a Policy Year<br>Maximum of [180] days per Policy Year |
| [**Wellness Benefit** | [$xxx] per visit, up to [1 visit] per Policy Year ] |
| [**Emergency Ambulance Benefit** | [$xxx] per ambulance trip, up to [1 payment] per Policy Year] |
| [**Outpatient Surgery Benefit** | [$xxx] Benefit, up to one payment per calendar day] |
| [**Critical Event Indemnity Benefit** | [$xxx] Benefit, up to one payment per category of covered event] |
| **Labor Dispute Waiver of Premium Benefit** | Premium waived for up to one year during participation in a lawful strike or lock-out. Principal Insured only. |
| **Benefit Percentages** | |
| Adults under age 70 | 100% of the Benefit Amounts |
| Adults age 70 and over | 50% of the Benefit Amounts, except as below<br>100% of the Wellness Benefit |
| [Covered Dependent Children: | 50% of the Benefit Amounts<br>100% of the Wellness Benefit ] |
| *[OR]*<br>[Covered Dependent Child: | 100% of the Benefit Amounts] |

**Termination Age:** None

## DEFINITIONS

When used in this Policy the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

**Complications of Pregnancy** (which are considered to be a Sickness under this Policy) means conditions arising during pregnancy whose diagnoses are separate from pregnancy but are unfavorably affected by pregnancy or are caused by pregnancy, such as: (1) infections of the genital or urinary tract; (2) acute nephritis; (3) nephrosis; (4) necrosis of the liver or kidney; (5) hypertension; and (6) similar conditions of comparable severity.

Complications of Pregnancy also includes abnormal maternal conditions directly related to and caused by pregnancy, such as: (1) hemorrhage of pregnancy; (2) rupture of uterus; (3) hydatidiform mole; (4) hyperemesis gravidarum; (5) eclampsia; (6) ectopic pregnancy; (7) non-elective caesarean section; and (8) spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy shall not include: (1) false labor; (2) occasional spotting; (3) physician prescribed rest; (4) morning sickness; or (5) other minor conditions associated with normal pregnancy.

**Confined or Confinement** means the Insured is a registered bed patient in a Hospital and is charged room and board by the facility. He must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. The Confinement must be Medically Necessary for the treatment of the Sickness or Injury.

Confinement does not include treatment received in the outpatient department of the facility.

**Covered Dependent** means any Dependent who is insured.

**Dependent** means: (1) Your lawful spouse (including your Domestic Partner); and (2) Your unmarried child(ren) who are under age 19 (or under age 25 if enrolled as a full-time student in an accredited post secondary school, college, or vocational or technical school). The child(ren) must be primarily dependent on You for support and maintenance.

Newborn children are covered from the moment of birth. Your adopted child is covered from the earlier of: (a) the moment the adoption is recognized as legal by Your home state; or (b) the date coverage is required to start by the laws of Your home state.

A newborn child is a Covered Dependent for 90 ~~31~~ days. Coverage then stops unless You: (a) send Us a written request to continue coverage; and (b) pays any required additional premium.

Coverage for adopted minors shall include coverage for any minor under the charge, care, and control of the insured whom the insured has filed a petition to adopt. The coverage of the minor shall be the same as provided for other members of the insured's family. Coverage shall begin on the date of the filing of a petition for adoption if the insured applies for coverage within sixty (60) days after the filing of the petition for adoption. However, the coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within sixty (60) days after the birth of the minor. The coverage shall terminate upon the dismissal or denial of a petition for adoption.

An unmarried dependent who is incapable of sustaining employment by reason of mental retardation or physical disability, who became so incapacitated prior to the attainment of the age of nineteen (19) years and who is chiefly dependent upon the policyholder for support and maintenance, shall not terminate but coverage shall continue so long as the contract remains in force and so long as the dependent remains in such condition.

**Domestic Partner** means the domestic partner of the Principal Insured, for whom we have been furnished and accepted proof:

a. of financial interdependence such as joint bank accounts, joint credit cards, jointly owned property and beneficiary designations for life insurance or pension plans;
b. of co-habitation;
c. of a prior relationship of a least 6 months, with an expectation of a future commitment;

d. of attainment of the age of majority;
e. that neither the Principal Insured or the domestic partner are legally married;
f. that the Principal Insured is not related by blood to the domestic partner; and
g. of filing as domestic partners, if the Principal Insured is a resident of a city, municipality or other governing jurisdiction that allows for filing as domestic partners.

The Principal Insured is responsible for notifying us upon dissolution of the domestic partnership and of any change in the status of the proof furnished to us evidencing the domestic partnership.

**Hospital** means an institution which meets all of the following requirements: (1) it must be operated according to law; (2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an Inpatient basis for which a charge is made; (3) it must provide diagnostic and surgical facilities supervised by Physicians; (4) Registered Nurses must be on 24 hour call or duty; and (5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

Except as specifically provided by this Policy or state law, the term Hospital does not include a facility, or part of a facility or Hospital, which is licensed as and providing care primarily as: (1) a rest facility, nursing facility, convalescent facility, or facility for the aged; (2) a chronic or skilled nursing facility, extended care facility, or a rehabilitation facility; or (3) a facility or program for treatment of mental illness, behavioral problems, or alcohol or drug abuse.

**Immediate Family** means Your spouse, Domestic Partner, child(ren), parents, brother(s), sister(s), in-laws or any member of Your household.

**Injury** means bodily Injury caused by an accident. It must be sustained by the Insured while coverage is in force. The Injury must be the direct cause of Loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

**Inpatient** means a registered bed patient Confined in a Hospital.

**Insured** means the Principal Insured and each Covered Dependent.

**Loss** means the Hospital Confinement of an Insured. Loss also means the occurrence of any other event for which benefits are payable under this Policy.

**Medically Necessary** means care, services, supplies, or treatment ordered by a Physician for the diagnosis or treatment of a Sickness or Injury. To be Medically Necessary, the care, services, or supplies must: (1) be appropriate and necessary for the symptoms, diagnosis or treatment, of the Insured's condition, disease, ailment, or Injury; (2) be provided for the diagnosis or direct care of the Insured's medical condition; (3) be in accordance with standards of good medical practice accepted by the organized medical community; (4) not be primarily for the convenience and/or comfort of the Insured, his family, his Physician or another provider of services; and (5) not be experimental or investigational.

In addition, Medically Necessary means care that is reasonable, necessary, and not custodial. Care is considered to be custodial when its primary purpose is to meet activities of daily living that could be met by persons other than Physicians and Nurses.

**Mental Disease or Disorder** means neurosis; psychoneurosis; psychopathy; psychosis; or mental or emotional disease or disorder of any kind without a demonstrable organic cause.

**Nurse** means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). A Nurse may not be You or a member of Your Immediate Family.

**Physician** means a licensed physician or other practitioner who is practicing within the scope of his license for the service or treatment provided. Neither You nor any member of Your Immediate Family will be considered a Physician.

**Policy Year** means each continuous 12-month period the policy is in force beginning from the Policy Effective Date.

**Pre-Existing Condition** means a condition for which medical: advice; diagnosis; care; or treatment was recommended by or received from a Physician during the six-month period immediately prior to the Insured's Effective Date of coverage. Pregnancy is not a Pre-Existing Condition.

**Premium** means the payment made for coverage.

**Principal Insured** means the person who enrolled for coverage and who is named as the "Principal Insured."

**Sickness** means an illness, disease, or physical condition which first manifests while the Insured is covered under the Policy. It also includes Complications of Pregnancy.

**We, Our and Us** means The Union Labor Life Insurance Company.

**You, Your, and Yours** means the Principal Insured.

## EFFECTIVE DATE OF INSURANCE

**Principal Insured:** The coverage takes effect at 12:01 A.M., Standard Time, at Your home on the Effective Date. Before coverage takes effect, You must enroll and pay the required premium. If no premium is required at time of enrollment, the first premium is due within 21 days of the Effective Date. Failure to pay the premium will void coverage from the Effective Date and no benefits will be paid.

**Dependent:** You may insure any Dependent on the later of: (a) the Effective Date; or (2) the date a Dependent is acquired.

If an Insured is Confined in a Hospital or an institution which provides medical care and treatment on the date his insurance would otherwise become effective, he will be insured the day following formal Hospital or institution discharge.

**Changes in Coverage:** To add a Dependent, You must: (a) send Us a written request; and (b) pay any required additional premium.

The effective date for any additional Dependents will be the date shown on Our endorsement or change form.

If a new eligible Dependent is added or if the change request increases the amount of coverage or adds new benefits, the Effective Date of insurance will be deferred if the Dependent is Confined in a Hospital or an institution which provides medical care and treatment on the date the insurance would otherwise become effective. The change will be effective the day following formal discharge from the Hospital or institution. This does apply to newborn children.

## HOSPITAL CONFINEMENT INDEMNITY BENEFIT

We will pay the benefit shown on the Schedule when We receive satisfactory proof of Loss that, as a result of a covered Injury or Sickness as defined in the Policy, the Insured is Confined in a Hospital as an Inpatient. The Confinement must begin while the Insured is covered under this Policy.

Benefits will be paid from the first day of Hospital Confinement and will continue for as long as the Insured is Confined for such Injury or Sickness, up to the maximum shown on the Schedule.

## LABOR DISPUTE WAIVER OF PREMIUM BENEFIT

We will waive premiums for the policy and any attached riders if the Principal Insured is Actively at Work and:
1. Participating in a lawful strike authorized by the Principal Insured's labor union; or
2. Locked-out of his or her place of employment as a result of a labor dispute between the Principal Insured's labor union and employer.

The premium to be waived for the premium period is:
1. The premium amount shown in the Schedule; plus
2. The cost for additional benefits provided by a rider, if any.

"Actively at Work" means the Principal Insured is performing all the regular duties of his or her occupation at the time the strike or lock-out begins.

This benefit begins on the next premium due date after the 30-day period immediately following the start of the strike or lock-out. We must receive at Our Administrative Office written notice and satisfactory proof to Us of the strike or lock-out. We must receive such notice and proof before benefits begin. This rider must be in force before the date the strike or lock-out begins. The Principal Insured must be a member in good standing. The Principal Insured must also be Actively at Work with the employer at the beginning of the strike. To receive benefits under this rider, satisfactory proof of the status of the strike or lock-out must be given Us when and as often as We may reasonably require, but in no event less than every 30 days.

We will stop providing benefits if proof of status is not provided as required. We must also be notified as soon as:
1. The strike or lock-out is resolved;
2. The Principal Insured returns to work or is offered the opportunity to return to work for his or her employer; or
3. The Principal Insured's employment is terminated.

Benefits end and premiums will again begin on the earliest of the following dates:
1. One year from the date benefits under this Rider began;
2. The next premium due date following the date the strike or lock-out is resolved;
3. The next premium due date following the date the Principal Insured returns to work or is offered the opportunity to return to work for his or her employer; or
4. The next premium due date following the date the Principal Insured's employment is terminated.

## EXCLUSIONS

Benefits will not be paid under this Policy for Hospital Confinements caused by, resulting from or contributed to by:
1. Injuries resulting from active military service; any active participation in a riot; armed conflict, or insurrection;
2. Declared or undeclared war or any act of war;
3. The use or taking of any narcotic, barbiturate, or any other drug by the Insured unless administered in a therapeutic dosage as prescribed by a Physician;
4. An Injury that occurs while the Insured has a blood alcohol level of .08 (by weight or volume) or higher;
5. Treatment of a Mental Disease or Disorder, alcoholism or drug addiction;
6. Pregnancy or childbirth (Complications of Pregnancy are covered on the same basis as Sickness);
7. Any Confinement rendered in a Hospital which does not comply with the Hospital definition (e.g. nursing facility, convalescent facility, or rehabilitation facility, etc. are not covered);
8. Any rehabilitative care in a Hospital;
9. Suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane;
10. Expenses incurred or care received outside of the United States beyond a period of 14 days of Hospital Confinement; or
11. An Injury that occurs while the Insured is committing an assault or felony.

## TERMINATION OF INSURANCE

If premium is not paid by the due date or during the 31 day Grace Period, coverage for all Insureds stops at the end of the Grace Period.

Dependent spouse or Domestic Partner coverage will end on the premium due date after a change in marital status. The Dependent spouse or Domestic Partner may apply for his own Policy. We must receive a written request within 60 days of the change in marital status. The spouse or Domestic Partner then pays the premium for individual coverage.

A Dependent child's coverage will end upon the earliest of the following: (a) marriage; (b) cessation of eligibility as a Dependent; or (c) attainment of age 19 (or age 25 if enrolled as a full-time student in an accredited post secondary school, college, or vocational or technical school).

If one of these events occurs, the Covered Dependent child may apply for his own Policy. We must receive a written request within 60 days of the date coverage stops. The child then pays the premium for individual coverage.

**Principal Insured's Death:** If coverage terminates due to Your death, the Covered Dependent spouse or Domestic Partner, if any, becomes the Principal Insured. Coverage may continue for any Dependent Children covered at the time of Your death. No evidence of insurability is needed. The spouse or Domestic Partner must provide Us with written notice of Your death within 60 days after the date of death. Premiums will be adjusted if necessary.

However, if there is no surviving spouse or Domestic Partner at the time of Your death, coverage for Dependent Children will end.

## EXTENSION OF BENEFITS

If an Insured's coverage terminates, for any reason except non-payment of premium, while the Insured is Hospital Confined, the Insured will be eligible for benefits for that Hospital Confinement just as if coverage had not ended.

No additional premium is needed for the extended benefit period after termination of coverage.

## HOW TO PAY THE PREMIUM

**Premium Payments:** You keep coverage in force by paying the premiums. The first premium is due prior to the Effective Date. After that, premiums are due on the first day of each renewal period.

**Grace Period:** You have a Grace Period of 31 days after the due date to pay the premium. The coverage stays in force if premium is paid during this Grace Period. If premium is not paid within this Grace Period, his coverage will lapse.

**Reinstatement of Coverage:** If an Insured's premium is not paid before the Grace Period ends, his coverage will lapse. Later acceptance of premium (by Us or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate his coverage. We may require an application for reinstatement. If so, the Insured will be given a conditional receipt for the premium. When the application is approved, the coverage will be reinstated as of the approval date. Lacking such approval, the coverage will be reinstated on the 45th day after the date of the conditional receipt unless We have previously written the Insured of Our disapproval. The reinstatement will cover only Loss due to an Injury sustained after the date of reinstatement; or to a Sickness that begins more than 10 days from the reinstatement date. In all other respects Our rights and the rights of the Insured will remain the same.

**Unpaid Premium:** When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

**Right To Adjust Premium Rates:** We may change rates, by class, on any premium due date. We will provide written notice at least 31 days before the date of change. *Rate increases will not be given prior to the first annual anniversary date of the policy and after the first annual anniversary date of the policy,* ~~*increases will not be given more frequently than once in a twelve (12) month period.*~~

All increases in rates, other than a change in age or an individual moving to another geographical area, must be submitted to our Department for approval.

## HOW TO FILE A CLAIM

**Notice of Claim:** Written notice of claim, satisfactory to Us, must be given within 30 days after a covered Loss starts, or as soon as reasonably possible. The notice must include the Insured's name and the Policy Number.

**Claim Forms:** When We receive a notice of claim, We will send forms for filing Proof of Loss. If the forms are not sent within fifteen days, the Insured should submit a written statement of the nature and extent of the Loss. This statement should be submitted within the time noted for Proof of Loss.

**Proof of Loss:** Written Proof of Loss, satisfactory to Us, must be given within 90 days after the Loss or as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless it was legally impossible to do so.

## CLAIM PAYMENT

**Payment of Claims:** Claims for benefits provided by this Policy will be paid as soon as written Proof of Loss is received. All benefits are paid directly to the Insured, unless directed otherwise. Any benefits unpaid at the Insured's death will be paid to his estate, except that We may pay benefits, up to $1,000 in benefits, to any relative by blood or marriage who We consider to be entitled to the benefits. Any payments We make in good faith will fully discharge Our liability.

**Right to Examine Hospital or Physician Records:** We may, at Our own expense, examine an Insured's Hospital and Physician records as often as necessary while a claim is pending.

**Physical Examination:** At Our expense, We have the right to have the Insured examined as often as reasonably necessary while a claim is pending. We will pay for these expenses.

## OTHER IMPORTANT INFORMATION

**Conformity to Law:** Any provision of this Policy which is in conflict with the laws of the state where the Policy is issued is amended to conform to the laws of that state.

**Dividends:** This is a Participating Policy. While it is in force, it is eligible for dividends as determined by Our Board of Directors. Any dividend will be paid in cash or used to reduce the next premium due.

**Unearned Premium:** Upon the death of an insured, the proceeds payable to the insured or his estate under the policy of individual accident and health insurance, delivered or issued for delivery in this state after June 17, 1981, shall include premiums paid, for accident and health insurance coverage for the insured, for any period beyond the end of the policy month in which the death occurred. Unearned premiums shall be paid in lump sum on a date no later than (30) days after the proof of the insured's death has been furnished to the insurer.

**Entire Contract:** This Policy, including the endorsements and attached papers, if any, is the entire contract between the parties. No change in this Policy will be effective until approved by one of Our officers. Such approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

**Legal Actions:** No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action shall be brought after 3 years from the time written Proof of Loss is required.

**Misstatement of Age:** If the Insured's age has been misstated in the enrollment form for insurance, the benefits payable will be those which the premiums paid would have purchased based upon his correct age. There will be an equitable adjustment of premium.

**Other Insurance in this Company:** If You are covered under more than one similar policy or group certificate issued by Us, we may limit the benefits available under the additional policies or certificates. We will return any excess premiums paid under the other policies or group certificates for the same period of coverage.

**Representations:** In the absence of fraud, all statements made by the policyholder or an insured person shall be deemed representations and not warranties, and no statement made for the purpose of effecting insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary.

**Time Limit on Certain Defenses:** No claim for a Loss incurred or commencing after twenty-four months from the date the Insured becomes covered will be reduced or denied on the ground that an Injury or Sickness had existed prior to the Effective Date of the Insured's coverage.

## LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

**DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do ~~not~~ not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

**NOTICE OF**
**THE ARKANSAS LIFE AND HEALTH**
**INSURANCE GUARANTY ASSOCIATION ACT**

The Arkansas Life and Health Insurance Guaranty Association Act (the "Act") provides protection, subject to certain limitations and exclusions, against loss under life and health insurance policies and annuity contracts issued by insolvent insurers licensed in this state. Some limitations and exclusions apply; some are listed below.

This notice is provided to you only to make you aware of the existence of the limited protection under the Act. It confers no rights to any policyholder or contract holder not provided under the Act. It does not change or vary any exclusion or limitation contained in the Act. Specific reference must be made to the Act to determine whether any particular policy or contract is covered, the amount of any coverage which may be available, and applicable limitations or exclusions.

Some of the limitations and exclusions are as follows:

1. The Act limits the amount the Guaranty Association is obligated to pay: The Association cannot pay more than what the insurer would owe under a policy or contract. Also, for any one insured, the Guaranty Association will pay a maximum of $300,000 no matter how many policies or contracts you have with the same insurer even if they provide different coverages. Within this overall $300,000 limit, the Association will pay a maximum of $300,000 in net cash surrender values, $300,000 in life insurance death benefits, $300,000 in present value of annuities, and $300,000 in disability or health insurance benefits. There is a $1,000,000 limit with respect to any one contract holder for unallocated annuity benefits irrespective of the number of participants in the plan.

2. You are not covered:
   a. If you are not a resident of Arkansas at the time the order of the insurer's insolvency was issued;
   b. Your insurer was not licensed in this state; or,
   c. Your insurer was a self-insured plan, trust or other similar entity, health maintenance organization or other entity excluded under the Act.

3. Obligations not specifically provided in the policy or contract are not covered by the Act. Examples of obligations, which are not covered by the Act, include damages or loss due to misrepresentations of policy benefits, inaccurate solicitation material, unfiled policy documents or endorsements, and extra-contractual damages, penalties and similar damages or claims.

4. Dividends or interest rate yields that do not meet specifications described in the Act are not covered under the Act.

**You should not rely upon coverage under the Act when buying a life or health insurance policy or selecting an insurer, and neither agents nor insurers should use the existence of the Guaranty Association to induce you to purchase a product from them.**

For more information relative to the Act, you may contact:

The Arkansas Life and Health
Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, AR 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

**Note To Reviewer**

**Created By:**
Carla Wallace on 12/20/2010 11:36 AM
**Last Edited By:**
Rosalind Minor
**Submitted On:**
12/30/2010 12:13 PM
**Subject:**
Right to Adjust Premium Rate Section
**Comments:**
The right to Adjust Premium Rate section has been hghlighted to reflect the correction regarding the deletion of the second sentence. The revised page has beenattached for your approval.

If you have questions, I can be reached at 202-962-2901 or cwallace@ullico.com

Thank you,

Carla Wallace
Sr. Compliance Analyst

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

**Note To Filer**

**Created By:**
Rosalind Minor on 12/16/2010 01:50 PM
**Last Edited By:**
Rosalind Minor
**Submitted On:**
12/30/2010 12:13 PM
**Subject:**
Your Note to Reviewer of 12/12/10
**Comments:**

You state in your note to Reviewer that you deleted the second sentence under right to Adjust Premium Rate. The revised page was not attached. Please send the revised page and the filing will be ready for approval.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

**Note To Reviewer**

**Created By:**
Carla Wallace on 12/12/2010 03:16 PM
**Last Edited By:**
Rosalind Minor
**Submitted On:**
12/30/2010 12:13 PM
**Subject:**
Right to adjust....
**Comments:**
Per your request, the second sentence has been deleted.

Thank you

Carla Wallace

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

**Note To Filer**

**Created By:**
Rosalind Minor on 12/09/2010 09:37 AM
**Last Edited By:**
Rosalind Minor
**Submitted On:**
12/30/2010 12:13 PM
**Subject:**
Right to Adjust Premium Rate
**Comments:**

Thank you for revising the about subject provision in the policy. The second sentence needs to be deleted. This is information which our Department sends to the insurance company when approving a rate increase. This does not need to be part of the policy.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

**Note To Reviewer**

**Created By:**
Carla Wallace on 12/08/2010 01:32 PM
**Last Edited By:**
Rosalind Minor
**Submitted On:**
12/30/2010 12:13 PM
**Subject:**
ULL-HIP-1010 AR Response.
**Comments:**
Good Afternoon,
The old forms with the new forms reflecting the changes have been added to the filing.
I have also added the rates in the rate schedule section. I can be reached at 202-962-2901 or cwallace@ullico.com

Thank you,

Carla Wallace

# The Union Labor Life Insurance Company

**("We, Us, Our, the Company")**

**[Administrative Office: 8403 Colesville Road, Silver Spring, MD 20910**
**Executive Office: 1625 Eye Street N.W., Washington DC 20006]**

## SUPPLEMENTAL HOSPITAL INDEMNITY INSURANCE POLICY

This insurance Policy pays benefits in the event of Hospital Confinements due to Sickness and Injury. The Policy is a legal contract. You rely on Us to honor its terms. We depend on Your payment of premium when due. This Policy is issued to the Policyholder. The Policy is issued in consideration of a completed enrollment form and timely payment of the premiums when due. Any payments are subject to all the terms and conditions of this Policy.

This Policy takes effect at 12:01 A.M. Standard Time at Your address on the Policy Effective Date shown on the Policy Schedule. After the first 12 month period, this Policy will automatically renew from year to year for additional 12 month periods subject to the Policy Termination provision. .

**60 Day Right to Examine the Policy:** If You are not satisfied, for any reason, You may return the Policy within 60 days of the date received. When returned, the Policy will be void from the beginning, and any premiums paid will be refunded. The Policy must be returned to Us at Our Administrative Office or to Our authorized producer.

**Pre-Existing Condition Limitation:** We will not pay a benefit for a Pre-existing Condition. Expenses for a Pre-Existing Condition will be eligible after the Insured has been covered for twelve consecutive months. The Pre-Existing Condition Limitation will apply to new Covered Dependents or an increase in benefits on the effective date of the change in coverage, but will not apply to coverage already in force.

**Guaranteed Renewable:** We guarantee to renew this Policy subject to the timely payment of premiums when due. No change will be made in the premium rates unless We make a change on all policies of this form in Your state.

**This is not a Medicare Supplement Policy.** If You are eligible for Medicare, please review the Medicare Supplement Buyer's Guide available from Us.

In Witness, this Policy is signed by the officers below.

[officer signature] [officer signature]

**PARTICIPATING**

**BENEFITS REDUCE AT AGE 70**
**[REDUCED BENEFITS FOR COVERED DEPENDENT CHILDREN]**

**TABLE OF CONTENTS**

## SCHEDULE

**Policyholder:** [John Doe]

**Policy Number** [12345]

**Principal Insured:** [John Doe]

**Policy Delivered In:** [state]

**Dependent Spouse/Domestic Partner:**
[Jane Doe]

**Dependent Children:**
[Mary Doe]

**Policy Effective Date:** [January 1, 2011]

**Premium Due Date:** [January 1, 2011]

**Premium:** [$xx.xx quarterly]

Insurance Benefits are determined by this Schedule and the terms of the Policy.

| **Description of Benefits** | **Benefit Amounts and Limits**<br>(Benefits apply to all Insureds unless otherwise noted) |
|---|---|
| **Hospital Confinement Indemnity Benefit** | [$xxx] daily benefit for the first [3] days in a Policy Year<br>[$xxx] daily benefit after the first [3] days in a Policy Year<br>Maximum of [180] days per Policy Year |
| [**Wellness Benefit** | [$xxx] per visit, up to [1 visit] per Policy Year ] |
| [**Emergency Ambulance Benefit** | [$xxx] per ambulance trip, up to [1 payment] per Policy Year] |
| [**Outpatient Surgery Benefit** | [$xxx] Benefit, up to one payment per calendar day] |
| [**Critical Event Indemnity Benefit** | [$xxx] Benefit, up to one payment per category of covered event] |
| **Labor Dispute Waiver of Premium Benefit** | Premium waived for up to one year during participation in a lawful strike or lock-out. Principal Insured only. |

| **Benefit Percentages** | |
|---|---|
| Adults under age 70 | 100% of the Benefit Amounts |
| Adults age 70 and over | 50% of the Benefit Amounts, except as below<br>100% of the Wellness Benefit |
| [Covered Dependent Children: | 50% of the Benefit Amounts<br>100% of the Wellness Benefit ] |
| *[OR]*<br>[Covered Dependent Child: | 100% of the Benefit Amounts] |

**Termination Age:** None

## DEFINITIONS

When used in this Policy the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

**Complications of Pregnancy** (which are considered to be a Sickness under this Policy) means conditions arising during pregnancy whose diagnoses are separate from pregnancy but are unfavorably affected by pregnancy or are caused by pregnancy, such as: (1) infections of the genital or urinary tract; (2) acute nephritis; (3) nephrosis; (4) necrosis of the liver or kidney; (5) hypertension; and (6) similar conditions of comparable severity.

Complications of Pregnancy also includes abnormal maternal conditions directly related to and caused by pregnancy, such as: (1) hemorrhage of pregnancy; (2) rupture of uterus; (3) hydatidiform mole; (4) hyperemesis gravidarum; (5) eclampsia; (6) ectopic pregnancy; (7) non-elective caesarean section; and (8) spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy shall not include: (1) false labor; (2) occasional spotting; (3) physician prescribed rest; (4) morning sickness; or (5) other minor conditions associated with normal pregnancy.

**Confined or Confinement** means the Insured is a registered bed patient in a Hospital and is charged room and board by the facility. He must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. The Confinement must be Medically Necessary for the treatment of the Sickness or Injury.

Confinement does not include treatment received in the outpatient department of the facility.

**Covered Dependent** means any Dependent who is insured.

**Dependent** means: (1) Your lawful spouse (including your Domestic Partner); and (2) Your unmarried child(ren) who are under age 19 (or under age 25 if enrolled as a full-time student in an accredited post secondary school, college, or vocational or technical school). The child(ren) must be primarily dependent on You for support and maintenance.

Newborn children are covered from the moment of birth. Your adopted child is covered from the earlier of: (a) the moment the adoption is recognized as legal by Your home state; or (b) the date coverage is required to start by the laws of Your home state.

A newborn child is a Covered Dependent for 90 days. Coverage then stops unless You: (a) send Us a written request to continue coverage; and (b) pays any required additional premium.

Coverage for adopted minors shall include coverage for any minor under the charge, care, and control of the insured whom the insured has filed a petition to adopt. The coverage of the minor shall be the same as provided for other members of the insured's family. Coverage shall begin on the date of the filing of a petition for adoption if the insured applies for coverage within sixty (60) days after the filing of the petition for adoption. However, the coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within sixty (60) days after the birth of the minor. The coverage shall terminate upon the dismissal or denial of a petition for adoption.

An unmarried dependent who is incapable of sustaining employment by reason of mental retardation or physical disability, who became so incapacitated prior to the attainment of the age of nineteen (19) years and who is chiefly dependent upon the policyholder for support and maintenance, shall not terminate but coverage shall continue so long as the contract remains in force and so long as the dependent remains in such condition.

**Domestic Partner** means the domestic partner of the Principal Insured, for whom we have been furnished and accepted proof:

a. of financial interdependence such as joint bank accounts, joint credit cards, jointly owned property and beneficiary designations for life insurance or pension plans;
b. of co-habitation;
c. of a prior relationship of a least 6 months, with an expectation of a future commitment;

d. of attainment of the age of majority;
e. that neither the Principal Insured or the domestic partner are legally married;
f. that the Principal Insured is not related by blood to the domestic partner; and
g. of filing as domestic partners, if the Principal Insured is a resident of a city, municipality or other governing jurisdiction that allows for filing as domestic partners.

The Principal Insured is responsible for notifying us upon dissolution of the domestic partnership and of any change in the status of the proof furnished to us evidencing the domestic partnership.

**Hospital** means an institution which meets all of the following requirements: (1) it must be operated according to law; (2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an Inpatient basis for which a charge is made; (3) it must provide diagnostic and surgical facilities supervised by Physicians; (4) Registered Nurses must be on 24 hour call or duty; and (5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

Except as specifically provided by this Policy or state law, the term Hospital does not include a facility, or part of a facility or Hospital, which is licensed as and providing care primarily as: (1) a rest facility, nursing facility, convalescent facility, or facility for the aged; (2) a chronic or skilled nursing facility, extended care facility, or a rehabilitation facility; or (3) a facility or program for treatment of mental illness, behavioral problems, or alcohol or drug abuse.

**Immediate Family** means Your spouse, Domestic Partner, child(ren), parents, brother(s), sister(s), in-laws or any member of Your household.

**Injury** means bodily Injury caused by an accident. It must be sustained by the Insured while coverage is in force. The Injury must be the direct cause of Loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

**Inpatient** means a registered bed patient Confined in a Hospital.

**Insured** means the Principal Insured and each Covered Dependent.

**Loss** means the Hospital Confinement of an Insured. Loss also means the occurrence of any other event for which benefits are payable under this Policy.

**Medically Necessary** means care, services, supplies, or treatment ordered by a Physician for the diagnosis or treatment of a Sickness or Injury. To be Medically Necessary, the care, services, or supplies must: (1) be appropriate and necessary for the symptoms, diagnosis or treatment, of the Insured's condition, disease, ailment, or Injury; (2) be provided for the diagnosis or direct care of the Insured's medical condition; (3) be in accordance with standards of good medical practice accepted by the organized medical community; (4) not be primarily for the convenience and/or comfort of the Insured, his family, his Physician or another provider of services; and (5) not be experimental or investigational.

In addition, Medically Necessary means care that is reasonable, necessary, and not custodial. Care is considered to be custodial when its primary purpose is to meet activities of daily living that could be met by persons other than Physicians and Nurses.

**Mental Disease or Disorder** means neurosis; psychoneurosis; psychopathy; psychosis; or mental or emotional disease or disorder of any kind without a demonstrable organic cause.

**Nurse** means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). A Nurse may not be You or a member of Your Immediate Family.

**Physician** means a licensed physician or other practitioner who is practicing within the scope of his license for the service or treatment provided. Neither You nor any member of Your Immediate Family will be considered a Physician.

**Policy Year** means each continuous 12-month period the policy is in force beginning from the Policy Effective Date.

**Pre-Existing Condition** means a condition for which medical: advice; diagnosis; care; or treatment was recommended by or received from a Physician during the six-month period immediately prior to the Insured's Effective Date of coverage. Pregnancy is not a Pre-Existing Condition.

**Premium** means the payment made for coverage.

**Principal Insured** means the person who enrolled for coverage and who is named as the "Principal Insured."

**Sickness** means an illness, disease, or physical condition which first manifests while the Insured is covered under the Policy. It also includes Complications of Pregnancy.

**We, Our and Us** means The Union Labor Life Insurance Company.

**You, Your, and Yours** means the Principal Insured.

## EFFECTIVE DATE OF INSURANCE

**Principal Insured:** The coverage takes effect at 12:01 A.M., Standard Time, at Your home on the Effective Date. Before coverage takes effect, You must enroll and pay the required premium. If no premium is required at time of enrollment, the first premium is due within 21 days of the Effective Date. Failure to pay the premium will void coverage from the Effective Date and no benefits will be paid.

**Dependent:** You may insure any Dependent on the later of: (a) the Effective Date; or (2) the date a Dependent is acquired.

If an Insured is Confined in a Hospital or an institution which provides medical care and treatment on the date his insurance would otherwise become effective, he will be insured the day following formal Hospital or institution discharge.

**Changes in Coverage:** To add a Dependent, You must: (a) send Us a written request; and (b) pay any required additional premium.

The effective date for any additional Dependents will be the date shown on Our endorsement or change form.

If a new eligible Dependent is added or if the change request increases the amount of coverage or adds new benefits, the Effective Date of insurance will be deferred if the Dependent is Confined in a Hospital or an institution which provides medical care and treatment on the date the insurance would otherwise become effective. The change will be effective the day following formal discharge from the Hospital or institution. This does apply to newborn children.

## HOSPITAL CONFINEMENT INDEMNITY BENEFIT

We will pay the benefit shown on the Schedule when We receive satisfactory proof of Loss that, as a result of a covered Injury or Sickness as defined in the Policy, the Insured is Confined in a Hospital as an Inpatient. The Confinement must begin while the Insured is covered under this Policy.

Benefits will be paid from the first day of Hospital Confinement and will continue for as long as the Insured is Confined for such Injury or Sickness, up to the maximum shown on the Schedule.

## LABOR DISPUTE WAIVER OF PREMIUM BENEFIT

We will waive premiums for the policy and any attached riders if the Principal Insured is Actively at Work and:
1. Participating in a lawful strike authorized by the Principal Insured's labor union; or
2. Locked-out of his or her place of employment as a result of a labor dispute between the Principal Insured's labor union and employer.

The premium to be waived for the premium period is:
1. The premium amount shown in the Schedule; plus
2. The cost for additional benefits provided by a rider, if any.

"Actively at Work" means the Principal Insured is performing all the regular duties of his or her occupation at the time the strike or lock-out begins.

This benefit begins on the next premium due date after the 30-day period immediately following the start of the strike or lock-out. We must receive at Our Administrative Office written notice and satisfactory proof to Us of the strike or lock-out. We must receive such notice and proof before benefits begin. This rider must be in force before the date the strike or lock-out begins. The Principal Insured must be a member in good standing. The Principal Insured must also be Actively at Work with the employer at the beginning of the strike. To receive benefits under this rider, satisfactory proof of the status of the strike or lock-out must be given Us when and as often as We may reasonably require, but in no event less than every 30 days.

We will stop providing benefits if proof of status is not provided as required. We must also be notified as soon as:
1. The strike or lock-out is resolved;
2. The Principal Insured returns to work or is offered the opportunity to return to work for his or her employer; or
3. The Principal Insured's employment is terminated.

Benefits end and premiums will again begin on the earliest of the following dates:
1. One year from the date benefits under this Rider began;
2. The next premium due date following the date the strike or lock-out is resolved;
3. The next premium due date following the date the Principal Insured returns to work or is offered the opportunity to return to work for his or her employer; or
4. The next premium due date following the date the Principal Insured's employment is terminated.

## EXCLUSIONS

Benefits will not be paid under this Policy for Hospital Confinements caused by, resulting from or contributed to by:
1. Injuries resulting from active military service; any active participation in a riot; armed conflict, or insurrection;
2. Declared or undeclared war or any act of war;
3. The use or taking of any narcotic, barbiturate, or any other drug by the Insured unless administered in a therapeutic dosage as prescribed by a Physician;
4. An Injury that occurs while the Insured has a blood alcohol level of .08 (by weight or volume) or higher;
5. Treatment of a Mental Disease or Disorder, alcoholism or drug addiction;
6. Pregnancy or childbirth (Complications of Pregnancy are covered on the same basis as Sickness);
7. Any Confinement rendered in a Hospital which does not comply with the Hospital definition (e.g. nursing facility, convalescent facility, or rehabilitation facility, etc. are not covered);
8. Any rehabilitative care in a Hospital;
9. Suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane;
10. Expenses incurred or care received outside of the United States beyond a period of 14 days of Hospital Confinement; or
11. An Injury that occurs while the Insured is committing an assault or felony.

## TERMINATION OF INSURANCE

If premium is not paid by the due date or during the 31 day Grace Period, coverage for all Insureds stops at the end of the Grace Period.

Dependent spouse or Domestic Partner coverage will end on the premium due date after a change in marital status. The Dependent spouse or Domestic Partner may apply for his own Policy. We must receive a written request within 60 days of the change in marital status. The spouse or Domestic Partner then pays the premium for individual coverage.

A Dependent child's coverage will end upon the earliest of the following: (a) marriage; (b) cessation of eligibility as a Dependent; or (c) attainment of age 19 (or age 25 if enrolled as a full-time student in an accredited post secondary school, college, or vocational or technical school).

If one of these events occurs, the Covered Dependent child may apply for his own Policy. We must receive a written request within 60 days of the date coverage stops. The child then pays the premium for individual coverage.

**Principal Insured's Death:** If coverage terminates due to Your death, the Covered Dependent spouse or Domestic Partner, if any, becomes the Principal Insured. Coverage may continue for any Dependent Children covered at the time of Your death. No evidence of insurability is needed. The spouse or Domestic Partner must provide Us with written notice of Your death within 60 days after the date of death. Premiums will be adjusted if necessary.

However, if there is no surviving spouse or Domestic Partner at the time of Your death, coverage for Dependent Children will end.

## EXTENSION OF BENEFITS

If an Insured's coverage terminates, for any reason except non-payment of premium, while the Insured is Hospital Confined, the Insured will be eligible for benefits for that Hospital Confinement just as if coverage had not ended.

No additional premium is needed for the extended benefit period after termination of coverage.

## HOW TO PAY THE PREMIUM

**Premium Payments:** You keep coverage in force by paying the premiums. The first premium is due prior to the Effective Date. After that, premiums are due on the first day of each renewal period.

**Grace Period:** You have a Grace Period of 31 days after the due date to pay the premium. The coverage stays in force if premium is paid during this Grace Period. If premium is not paid within this Grace Period, his coverage will lapse.

**Reinstatement of Coverage:** If an Insured's premium is not paid before the Grace Period ends, his coverage will lapse. Later acceptance of premium (by Us or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate his coverage. We may require an application for reinstatement. If so, the Insured will be given a conditional receipt for the premium. When the application is approved, the coverage will be reinstated as of the approval date. Lacking such approval, the coverage will be reinstated on the 45th day after the date of the conditional receipt unless We have previously written the Insured of Our disapproval. The reinstatement will cover only Loss due to an Injury sustained after the date of reinstatement; or to a Sickness that begins more than 10 days from the reinstatement date. In all other respects Our rights and the rights of the Insured will remain the same.

**Unpaid Premium:** When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

**Right To Adjust Premium Rates:** We may change rates, by class, on any premium due date. We will provide written notice at least 31 days before the date of change. *Rate increases will not be given prior to the first annual anniversary date of the policy and after the first annual anniversary date of the policy, increases will not be given more frequently than once in a twelve (12) month period.*

All increases in rates, other than a change in age or an individual moving to another geographical area, must be submitted to our Department for approval.

## HOW TO FILE A CLAIM

**Notice of Claim:** Written notice of claim, satisfactory to Us, must be given within 30 days after a covered Loss starts, or as soon as reasonably possible. The notice must include the Insured's name and the Policy Number.

**Claim Forms:** When We receive a notice of claim, We will send forms for filing Proof of Loss. If the forms are not sent within fifteen days, the Insured should submit a written statement of the nature and extent of the Loss. This statement should be submitted within the time noted for Proof of Loss.

**Proof of Loss:** Written Proof of Loss, satisfactory to Us, must be given within 90 days after the Loss or as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless it was legally impossible to do so.

## CLAIM PAYMENT

**Payment of Claims:** Claims for benefits provided by this Policy will be paid as soon as written Proof of Loss is received. All benefits are paid directly to the Insured, unless directed otherwise. Any benefits unpaid at the Insured's death will be paid to his estate, except that We may pay benefits, up to $1,000 in benefits, to any relative by blood or marriage who We consider to be entitled to the benefits. Any payments We make in good faith will fully discharge Our liability.

**Right to Examine Hospital or Physician Records:** We may, at Our own expense, examine an Insured's Hospital and Physician records as often as necessary while a claim is pending.

**Physical Examination:** At Our expense, We have the right to have the Insured examined as often as reasonably necessary while a claim is pending. We will pay for these expenses.

## OTHER IMPORTANT INFORMATION

**Conformity to Law:** Any provision of this Policy which is in conflict with the laws of the state where the Policy is issued is amended to conform to the laws of that state.

**Dividends:** This is a Participating Policy. While it is in force, it is eligible for dividends as determined by Our Board of Directors. Any dividend will be paid in cash or used to reduce the next premium due.

**Unearned Premium:** Upon the death of an insured, the proceeds payable to the insured or his estate under the policy of individual accident and health insurance, delivered or issued for delivery in this state after June 17, 1981, shall include premiums paid, for accident and health insurance coverage for the insured, for any period beyond the end of the policy month in which the death occurred. Unearned premiums shall be paid in lump sum on a date no later than (30) days after the proof of the insured's death has been furnished to the insurer.

**Entire Contract:** This Policy, including the endorsements and attached papers, if any, is the entire contract between the parties. No change in this Policy will be effective until approved by one of Our officers. Such approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

**Legal Actions:** No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action shall be brought after 3 years from the time written Proof of Loss is required.

**Misstatement of Age:** If the Insured's age has been misstated in the enrollment form for insurance, the benefits payable will be those which the premiums paid would have purchased based upon his correct age. There will be an equitable adjustment of premium.

**Other Insurance in this Company:** If You are covered under more than one similar policy or group certificate issued by Us, we may limit the benefits available under the additional policies or certificates. We will return any excess premiums paid under the other policies or group certificates for the same period of coverage.

**Representations:** In the absence of fraud, all statements made by the policyholder or an insured person shall be deemed representations and not warranties, and no statement made for the purpose of effecting insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary.

**Time Limit on Certain Defenses:** No claim for a Loss incurred or commencing after twenty-four months from the date the Insured becomes covered will be reduced or denied on the ground that an Injury or Sickness had existed prior to the Effective Date of the Insured's coverage.

**LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

**DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do ~~not~~ not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

**NOTICE OF**
**THE ARKANSAS LIFE AND HEALTH**
**INSURANCE GUARANTY ASSOCIATION ACT**

The Arkansas Life and Health Insurance Guaranty Association Act (the "Act") provides protection, subject to certain limitations and exclusions, against loss under life and health insurance policies and annuity contracts issued by insolvent insurers licensed in this state. Some limitations and exclusions apply; some are listed below.

This notice is provided to you only to make you aware of the existence of the limited protection under the Act. It confers no rights to any policyholder or contract holder not provided under the Act. It does not change or vary any exclusion or limitation contained in the Act. Specific reference must be made to the Act to determine whether any particular policy or contract is covered, the amount of any coverage which may be available, and applicable limitations or exclusions.

Some of the limitations and exclusions are as follows:

1. The Act limits the amount the Guaranty Association is obligated to pay: The Association cannot pay more than what the insurer would owe under a policy or contract. Also, for any one insured, the Guaranty Association will pay a maximum of $300,000 no matter how many policies or contracts you have with the same insurer even if they provide different coverages. Within this overall $300,000 limit, the Association will pay a maximum of $300,000 in net cash surrender values, $300,000 in life insurance death benefits, $300,000 in present value of annuities, and $300,000 in disability or health insurance benefits. There is a $1,000,000 limit with respect to any one contract holder for unallocated annuity benefits irrespective of the number of participants in the plan.

2. You are not covered:
   a. If you are not a resident of Arkansas at the time the order of the insurer's insolvency was issued;
   b. Your insurer was not licensed in this state; or,
   c. Your insurer was a self-insured plan, trust or other similar entity, health maintenance organization or other entity excluded under the Act.

3. Obligations not specifically provided in the policy or contract are not covered by the Act. Examples of obligations, which are not covered by the Act, include damages or loss due to misrepresentations of policy benefits, inaccurate solicitation material, unfiled policy documents or endorsements, and extra-contractual damages, penalties and similar damages or claims.

4. Dividends or interest rate yields that do not meet specifications described in the Act are not covered under the Act.

**You should not rely upon coverage under the Act when buying a life or health insurance policy or selecting an insurer, and neither agents nor insurers should use the existence of the Guaranty Association to induce you to purchase a product from them.**

For more information relative to the Act, you may contact:

The Arkansas Life and Health
Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, AR 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

# The Union Labor Life Insurance Company

**("We, Us, Our, the Company")**

**[Administrative Office: 8403 Colesville Road, Silver Spring, MD 20910**
**Executive Office: 1625 Eye Street N.W., Washington DC 20006]**

## SUPPLEMENTAL HOSPITAL INDEMNITY INSURANCE POLICY

This insurance Policy pays benefits in the event of Hospital Confinements due to Sickness and Injury. The Policy is a legal contract. You rely on Us to honor its terms. We depend on Your payment of premium when due. This Policy is issued to the Policyholder. The Policy is issued in consideration of a completed enrollment form and timely payment of the premiums when due. Any payments are subject to all the terms and conditions of this Policy.

This Policy takes effect at 12:01 A.M. Standard Time at Your address on the Policy Effective Date shown on the Policy Schedule. After the first 12 month period, this Policy will automatically renew from year to year for additional 12 month periods subject to the Policy Termination provision. .

**60 Day Right to Examine the Policy:** If You are not satisfied, for any reason, You may return the Policy within 60 days of the date received. When returned, the Policy will be void from the beginning, and any premiums paid will be refunded. The Policy must be returned to Us at Our Administrative Office or to Our authorized producer.

**Pre-Existing Condition Limitation:** We will not pay a benefit for a Pre-existing Condition. Expenses for a Pre-Existing Condition will be eligible after the Insured has been covered for twelve consecutive months. The Pre-Existing Condition Limitation will apply to new Covered Dependents or an increase in benefits on the effective date of the change in coverage, but will not apply to coverage already in force.

**Guaranteed Renewable:** We guarantee to renew this Policy subject to the timely payment of premiums when due. No change will be made in the premium rates unless We make a change on all policies of this form in Your state.

**This is not a Medicare Supplement Policy.** If You are eligible for Medicare, please review the Medicare Supplement Buyer's Guide available from Us.

In Witness, this Policy is signed by the officers below.

[officer signature] [officer signature]

**PARTICIPATING**

**BENEFITS REDUCE AT AGE 70**
**[REDUCED BENEFITS FOR COVERED DEPENDENT CHILDREN]**

**TABLE OF CONTENTS**

## SCHEDULE

**Policyholder:** [John Doe]

**Policy Number** [12345]

**Principal Insured:** [John Doe]

**Policy Delivered In:** [state]

**Dependent Spouse/Domestic Partner:**
[Jane Doe]

**Dependent Children:**
[Mary Doe]

**Policy Effective Date:** [January 1, 2011]

**Premium Due Date:** [January 1, 2011]

**Premium:** [$xx.xx quarterly]

Insurance Benefits are determined by this Schedule and the terms of the Policy.

| **Description of Benefits** | **Benefit Amounts and Limits**<br>(Benefits apply to all Insureds unless otherwise noted) |
|---|---|
| **Hospital Confinement Indemnity Benefit** | [$xxx] daily benefit for the first [3] days in a Policy Year<br>[$xxx] daily benefit after the first [3] days in a Policy Year<br>Maximum of [180] days per Policy Year |
| [**Wellness Benefit** | [$xxx] per visit, up to [1 visit] per Policy Year ] |
| [**Emergency Ambulance Benefit** | [$xxx] per ambulance trip, up to [1 payment] per Policy Year] |
| [**Outpatient Surgery Benefit** | [$xxx] Benefit, up to one payment per calendar day] |
| [**Critical Event Indemnity Benefit** | [$xxx] Benefit, up to one payment per category of covered event] |
| **Labor Dispute Waiver of Premium Benefit** | Premium waived for up to one year during participation in a lawful strike or lock-out. Principal Insured only. |
| **Benefit Percentages** | |
| Adults under age 70 | 100% of the Benefit Amounts |
| Adults age 70 and over | 50% of the Benefit Amounts, except as below<br>100% of the Wellness Benefit |
| [Covered Dependent Children: | 50% of the Benefit Amounts<br>100% of the Wellness Benefit ] |
| *[OR]*<br>[Covered Dependent Child: | 100% of the Benefit Amounts] |

**Termination Age:** None

## DEFINITIONS

When used in this Policy the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

**Complications of Pregnancy** (which are considered to be a Sickness under this Policy) means conditions arising during pregnancy whose diagnoses are separate from pregnancy but are unfavorably affected by pregnancy or are caused by pregnancy, such as: (1) infections of the genital or urinary tract; (2) acute nephritis; (3) nephrosis; (4) necrosis of the liver or kidney; (5) hypertension; and (6) similar conditions of comparable severity.

Complications of Pregnancy also includes abnormal maternal conditions directly related to and caused by pregnancy, such as: (1) hemorrhage of pregnancy; (2) rupture of uterus; (3) hydatidiform mole; (4) hyperemesis gravidarum; (5) eclampsia; (6) ectopic pregnancy; (7) non-elective caesarean section; and (8) spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy shall not include: (1) false labor; (2) occasional spotting; (3) physician prescribed rest; (4) morning sickness; or (5) other minor conditions associated with normal pregnancy.

**Confined or Confinement** means the Insured is a registered bed patient in a Hospital and is charged room and board by the facility. He must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. The Confinement must be Medically Necessary for the treatment of the Sickness or Injury.

Confinement does not include treatment received in the outpatient department of the facility.

**Covered Dependent** means any Dependent who is insured.

**Dependent** means: (1) Your lawful spouse (including your Domestic Partner); and (2) Your unmarried child(ren) who are under age 19 (or under age 25 if enrolled as a full-time student in an accredited post secondary school, college, or vocational or technical school). The child(ren) must be primarily dependent on You for support and maintenance.

Newborn children are covered from the moment of birth. Your adopted child is covered from the earlier of: (a) the moment the adoption is recognized as legal by Your home state; or (b) the date coverage is required to start by the laws of Your home state.

A newborn child is a Covered Dependent for 90 ~~31~~ days. Coverage then stops unless You: (a) send Us a written request to continue coverage; and (b) pays any required additional premium.

Coverage for adopted minors shall include coverage for any minor under the charge, care, and control of the insured whom the insured has filed a petition to adopt. The coverage of the minor shall be the same as provided for other members of the insured's family. Coverage shall begin on the date of the filing of a petition for adoption if the insured applies for coverage within sixty (60) days after the filing of the petition for adoption. However, the coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within sixty (60) days after the birth of the minor. The coverage shall terminate upon the dismissal or denial of a petition for adoption.

An unmarried dependent who is incapable of sustaining employment by reason of mental retardation or physical disability, who became so incapacitated prior to the attainment of the age of nineteen (19) years and who is chiefly dependent upon the policyholder for support and maintenance, shall not terminate but coverage shall continue so long as the contract remains in force and so long as the dependent remains in such condition.

**Domestic Partner** means the domestic partner of the Principal Insured, for whom we have been furnished and accepted proof:

a. of financial interdependence such as joint bank accounts, joint credit cards, jointly owned property and beneficiary designations for life insurance or pension plans;
b. of co-habitation;
c. of a prior relationship of a least 6 months, with an expectation of a future commitment;

d. of attainment of the age of majority;
e. that neither the Principal Insured or the domestic partner are legally married;
f. that the Principal Insured is not related by blood to the domestic partner; and
g. of filing as domestic partners, if the Principal Insured is a resident of a city, municipality or other governing jurisdiction that allows for filing as domestic partners.

The Principal Insured is responsible for notifying us upon dissolution of the domestic partnership and of any change in the status of the proof furnished to us evidencing the domestic partnership.

**Hospital** means an institution which meets all of the following requirements: (1) it must be operated according to law; (2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an Inpatient basis for which a charge is made; (3) it must provide diagnostic and surgical facilities supervised by Physicians; (4) Registered Nurses must be on 24 hour call or duty; and (5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

Except as specifically provided by this Policy or state law, the term Hospital does not include a facility, or part of a facility or Hospital, which is licensed as and providing care primarily as: (1) a rest facility, nursing facility, convalescent facility, or facility for the aged; (2) a chronic or skilled nursing facility, extended care facility, or a rehabilitation facility; or (3) a facility or program for treatment of mental illness, behavioral problems, or alcohol or drug abuse.

**Immediate Family** means Your spouse, Domestic Partner, child(ren), parents, brother(s), sister(s), in-laws or any member of Your household.

**Injury** means bodily Injury caused by an accident. It must be sustained by the Insured while coverage is in force. The Injury must be the direct cause of Loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

**Inpatient** means a registered bed patient Confined in a Hospital.

**Insured** means the Principal Insured and each Covered Dependent.

**Loss** means the Hospital Confinement of an Insured. Loss also means the occurrence of any other event for which benefits are payable under this Policy.

**Medically Necessary** means care, services, supplies, or treatment ordered by a Physician for the diagnosis or treatment of a Sickness or Injury. To be Medically Necessary, the care, services, or supplies must: (1) be appropriate and necessary for the symptoms, diagnosis or treatment, of the Insured's condition, disease, ailment, or Injury; (2) be provided for the diagnosis or direct care of the Insured's medical condition; (3) be in accordance with standards of good medical practice accepted by the organized medical community; (4) not be primarily for the convenience and/or comfort of the Insured, his family, his Physician or another provider of services; and (5) not be experimental or investigational.

In addition, Medically Necessary means care that is reasonable, necessary, and not custodial. Care is considered to be custodial when its primary purpose is to meet activities of daily living that could be met by persons other than Physicians and Nurses.

**Mental Disease or Disorder** means neurosis; psychoneurosis; psychopathy; psychosis; or mental or emotional disease or disorder of any kind without a demonstrable organic cause.

**Nurse** means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). A Nurse may not be You or a member of Your Immediate Family.

**Physician** means a licensed physician or other practitioner who is practicing within the scope of his license for the service or treatment provided. Neither You nor any member of Your Immediate Family will be considered a Physician.

**Policy Year** means each continuous 12-month period the policy is in force beginning from the Policy Effective Date.

**Pre-Existing Condition** means a condition for which medical: advice; diagnosis; care; or treatment was recommended by or received from a Physician during the six-month period immediately prior to the Insured's Effective Date of coverage. Pregnancy is not a Pre-Existing Condition.

**Premium** means the payment made for coverage.

**Principal Insured** means the person who enrolled for coverage and who is named as the "Principal Insured."

**Sickness** means an illness, disease, or physical condition which first manifests while the Insured is covered under the Policy. It also includes Complications of Pregnancy.

**We, Our and Us** means The Union Labor Life Insurance Company.

**You, Your, and Yours** means the Principal Insured.

## EFFECTIVE DATE OF INSURANCE

**Principal Insured:** The coverage takes effect at 12:01 A.M., Standard Time, at Your home on the Effective Date. Before coverage takes effect, You must enroll and pay the required premium. If no premium is required at time of enrollment, the first premium is due within 21 days of the Effective Date. Failure to pay the premium will void coverage from the Effective Date and no benefits will be paid.

**Dependent:** You may insure any Dependent on the later of: (a) the Effective Date; or (2) the date a Dependent is acquired.

If an Insured is Confined in a Hospital or an institution which provides medical care and treatment on the date his insurance would otherwise become effective, he will be insured the day following formal Hospital or institution discharge.

**Changes in Coverage:** To add a Dependent, You must: (a) send Us a written request; and (b) pay any required additional premium.

The effective date for any additional Dependents will be the date shown on Our endorsement or change form.

If a new eligible Dependent is added or if the change request increases the amount of coverage or adds new benefits, the Effective Date of insurance will be deferred if the Dependent is Confined in a Hospital or an institution which provides medical care and treatment on the date the insurance would otherwise become effective. The change will be effective the day following formal discharge from the Hospital or institution. This does apply to newborn children.

## HOSPITAL CONFINEMENT INDEMNITY BENEFIT

We will pay the benefit shown on the Schedule when We receive satisfactory proof of Loss that, as a result of a covered Injury or Sickness as defined in the Policy, the Insured is Confined in a Hospital as an Inpatient. The Confinement must begin while the Insured is covered under this Policy.

Benefits will be paid from the first day of Hospital Confinement and will continue for as long as the Insured is Confined for such Injury or Sickness, up to the maximum shown on the Schedule.

## LABOR DISPUTE WAIVER OF PREMIUM BENEFIT

We will waive premiums for the policy and any attached riders if the Principal Insured is Actively at Work and:
1. Participating in a lawful strike authorized by the Principal Insured's labor union; or
2. Locked-out of his or her place of employment as a result of a labor dispute between the Principal Insured's labor union and employer.

The premium to be waived for the premium period is:
1. The premium amount shown in the Schedule; plus
2. The cost for additional benefits provided by a rider, if any.

"Actively at Work" means the Principal Insured is performing all the regular duties of his or her occupation at the time the strike or lock-out begins.

This benefit begins on the next premium due date after the 30-day period immediately following the start of the strike or lock-out. We must receive at Our Administrative Office written notice and satisfactory proof to Us of the strike or lock-out. We must receive such notice and proof before benefits begin. This rider must be in force before the date the strike or lock-out begins. The Principal Insured must be a member in good standing. The Principal Insured must also be Actively at Work with the employer at the beginning of the strike. To receive benefits under this rider, satisfactory proof of the status of the strike or lock-out must be given Us when and as often as We may reasonably require, but in no event less than every 30 days.

We will stop providing benefits if proof of status is not provided as required. We must also be notified as soon as:
1. The strike or lock-out is resolved;
2. The Principal Insured returns to work or is offered the opportunity to return to work for his or her employer; or
3. The Principal Insured's employment is terminated.

Benefits end and premiums will again begin on the earliest of the following dates:
1. One year from the date benefits under this Rider began;
2. The next premium due date following the date the strike or lock-out is resolved;
3. The next premium due date following the date the Principal Insured returns to work or is offered the opportunity to return to work for his or her employer; or
4. The next premium due date following the date the Principal Insured's employment is terminated.

## EXCLUSIONS

Benefits will not be paid under this Policy for Hospital Confinements caused by, resulting from or contributed to by:
1. Injuries resulting from active military service; any active participation in a riot; armed conflict, or insurrection;
2. Declared or undeclared war or any act of war;
3. The use or taking of any narcotic, barbiturate, or any other drug by the Insured unless administered in a therapeutic dosage as prescribed by a Physician;
4. An Injury that occurs while the Insured has a blood alcohol level of .08 (by weight or volume) or higher;
5. Treatment of a Mental Disease or Disorder, alcoholism or drug addiction;
6. Pregnancy or childbirth (Complications of Pregnancy are covered on the same basis as Sickness);
7. Any Confinement rendered in a Hospital which does not comply with the Hospital definition (e.g. nursing facility, convalescent facility, or rehabilitation facility, etc. are not covered);
8. Any rehabilitative care in a Hospital;
9. Suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane;
10. Expenses incurred or care received outside of the United States beyond a period of 14 days of Hospital Confinement; or
11. An Injury that occurs while the Insured is committing an assault or felony.

## TERMINATION OF INSURANCE

If premium is not paid by the due date or during the 31 day Grace Period, coverage for all Insureds stops at the end of the Grace Period.

Dependent spouse or Domestic Partner coverage will end on the premium due date after a change in marital status. The Dependent spouse or Domestic Partner may apply for his own Policy. We must receive a written request within 60 days of the change in marital status. The spouse or Domestic Partner then pays the premium for individual coverage.

A Dependent child's coverage will end upon the earliest of the following: (a) marriage; (b) cessation of eligibility as a Dependent; or (c) attainment of age 19 (or age 25 if enrolled as a full-time student in an accredited post secondary school, college, or vocational or technical school).

If one of these events occurs, the Covered Dependent child may apply for his own Policy. We must receive a written request within 60 days of the date coverage stops. The child then pays the premium for individual coverage.

**Principal Insured's Death:** If coverage terminates due to Your death, the Covered Dependent spouse or Domestic Partner, if any, becomes the Principal Insured. Coverage may continue for any Dependent Children covered at the time of Your death. No evidence of insurability is needed. The spouse or Domestic Partner must provide Us with written notice of Your death within 60 days after the date of death. Premiums will be adjusted if necessary.

However, if there is no surviving spouse or Domestic Partner at the time of Your death, coverage for Dependent Children will end.

## EXTENSION OF BENEFITS

If an Insured's coverage terminates, for any reason except non-payment of premium, while the Insured is Hospital Confined, the Insured will be eligible for benefits for that Hospital Confinement just as if coverage had not ended.

No additional premium is needed for the extended benefit period after termination of coverage.

## HOW TO PAY THE PREMIUM

**Premium Payments:** You keep coverage in force by paying the premiums. The first premium is due prior to the Effective Date. After that, premiums are due on the first day of each renewal period.

**Grace Period:** You have a Grace Period of 31 days after the due date to pay the premium. The coverage stays in force if premium is paid during this Grace Period. If premium is not paid within this Grace Period, his coverage will lapse.

**Reinstatement of Coverage:** If an Insured's premium is not paid before the Grace Period ends, his coverage will lapse. Later acceptance of premium (by Us or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate his coverage. We may require an application for reinstatement. If so, the Insured will be given a conditional receipt for the premium. When the application is approved, the coverage will be reinstated as of the approval date. Lacking such approval, the coverage will be reinstated on the 45th day after the date of the conditional receipt unless We have previously written the Insured of Our disapproval. The reinstatement will cover only Loss due to an Injury sustained after the date of reinstatement; or to a Sickness that begins more than 10 days from the reinstatement date. In all other respects Our rights and the rights of the Insured will remain the same.

**Unpaid Premium:** When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

**Right To Adjust Premium Rates:** We may change rates, by class, on any premium due date. We will provide written notice at least 31 days before the date of change. *Rate increases will not be given prior to the first annual anniversary date of the policy and after the first annual anniversary date of the policy, increases will not be given more frequently than once in a twelve (12) month period.*

All increases in rates, other than a change in age or an individual moving to another geographical area, must be submitted to our Department for approval.

## HOW TO FILE A CLAIM

**Notice of Claim:** Written notice of claim, satisfactory to Us, must be given within 30 days after a covered Loss starts, or as soon as reasonably possible. The notice must include the Insured's name and the Policy Number.

**Claim Forms:** When We receive a notice of claim, We will send forms for filing Proof of Loss. If the forms are not sent within fifteen days, the Insured should submit a written statement of the nature and extent of the Loss. This statement should be submitted within the time noted for Proof of Loss.

**Proof of Loss:** Written Proof of Loss, satisfactory to Us, must be given within 90 days after the Loss or as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless it was legally impossible to do so.

## CLAIM PAYMENT

**Payment of Claims:** Claims for benefits provided by this Policy will be paid as soon as written Proof of Loss is received. All benefits are paid directly to the Insured, unless directed otherwise. Any benefits unpaid at the Insured's death will be paid to his estate, except that We may pay benefits, up to $1,000 in benefits, to any relative by blood or marriage who We consider to be entitled to the benefits. Any payments We make in good faith will fully discharge Our liability.

**Right to Examine Hospital or Physician Records:** We may, at Our own expense, examine an Insured's Hospital and Physician records as often as necessary while a claim is pending.

**Physical Examination:** At Our expense, We have the right to have the Insured examined as often as reasonably necessary while a claim is pending. We will pay for these expenses.

## OTHER IMPORTANT INFORMATION

**Conformity to Law:** Any provision of this Policy which is in conflict with the laws of the state where the Policy is issued is amended to conform to the laws of that state.

**Dividends:** This is a Participating Policy. While it is in force, it is eligible for dividends as determined by Our Board of Directors. Any dividend will be paid in cash or used to reduce the next premium due.

**Unearned Premium:** Upon the death of an insured, the proceeds payable to the insured or his estate under the policy of individual accident and health insurance, delivered or issued for delivery in this state after June 17, 1981, shall include premiums paid, for accident and health insurance coverage for the insured, for any period beyond the end of the policy month in which the death occurred. Unearned premiums shall be paid in lump sum on a date no later than (30) days after the proof of the insured's death has been furnished to the insurer.

**Entire Contract:** This Policy, including the endorsements and attached papers, if any, is the entire contract between the parties. No change in this Policy will be effective until approved by one of Our officers. Such approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

**Legal Actions:** No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action shall be brought after 3 years from the time written Proof of Loss is required.

**Misstatement of Age:** If the Insured's age has been misstated in the enrollment form for insurance, the benefits payable will be those which the premiums paid would have purchased based upon his correct age. There will be an equitable adjustment of premium.

**Other Insurance in this Company:** If You are covered under more than one similar policy or group certificate issued by Us, we may limit the benefits available under the additional policies or certificates. We will return any excess premiums paid under the other policies or group certificates for the same period of coverage.

**Representations:** In the absence of fraud, all statements made by the policyholder or an insured person shall be deemed representations and not warranties, and no statement made for the purpose of effecting insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary.

**Time Limit on Certain Defenses:** No claim for a Loss incurred or commencing after twenty-four months from the date the Insured becomes covered will be reduced or denied on the ground that an Injury or Sickness had existed prior to the Effective Date of the Insured's coverage.

## LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

**DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do ~~not~~ not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

**NOTICE OF**
**THE ARKANSAS LIFE AND HEALTH**
**INSURANCE GUARANTY ASSOCIATION ACT**

The Arkansas Life and Health Insurance Guaranty Association Act (the "Act") provides protection, subject to certain limitations and exclusions, against loss under life and health insurance policies and annuity contracts issued by insolvent insurers licensed in this state. Some limitations and exclusions apply; some are listed below.

This notice is provided to you only to make you aware of the existence of the limited protection under the Act. It confers no rights to any policyholder or contract holder not provided under the Act. It does not change or vary any exclusion or limitation contained in the Act. Specific reference must be made to the Act to determine whether any particular policy or contract is covered, the amount of any coverage which may be available, and applicable limitations or exclusions.

Some of the limitations and exclusions are as follows:

1. The Act limits the amount the Guaranty Association is obligated to pay: The Association cannot pay more than what the insurer would owe under a policy or contract. Also, for any one insured, the Guaranty Association will pay a maximum of $300,000 no matter how many policies or contracts you have with the same insurer even if they provide different coverages. Within this overall $300,000 limit, the Association will pay a maximum of $300,000 in net cash surrender values, $300,000 in life insurance death benefits, $300,000 in present value of annuities, and $300,000 in disability or health insurance benefits. There is a $1,000,000 limit with respect to any one contract holder for unallocated annuity benefits irrespective of the number of participants in the plan.

2. You are not covered:
   a. If you are not a resident of Arkansas at the time the order of the insurer's insolvency was issued;
   b. Your insurer was not licensed in this state; or,
   c. Your insurer was a self-insured plan, trust or other similar entity, health maintenance organization or other entity excluded under the Act.

3. Obligations not specifically provided in the policy or contract are not covered by the Act. Examples of obligations, which are not covered by the Act, include damages or loss due to misrepresentations of policy benefits, inaccurate solicitation material, unfiled policy documents or endorsements, and extra-contractual damages, penalties and similar damages or claims.

4. Dividends or interest rate yields that do not meet specifications described in the Act are not covered under the Act.

**You should not rely upon coverage under the Act when buying a life or health insurance policy or selecting an insurer, and neither agents nor insurers should use the existence of the Guaranty Association to induce you to purchase a product from them.**

For more information relative to the Act, you may contact:

The Arkansas Life and Health
Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, AR 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

Rates ULL-HIP-1010
Incremental Benefit Days: 2

## Appendix A.1

| | |
|---|---|
| **Premium Payment Mode:** | Annual |
| **Incremental Benefit Days:** | |

| **Level #1** | | | **Individual Plan- Annual Premium** | | **Individual Plus One- Annual Premium** | | **Family Plan- Annual Premium** | |
|---|---|---|---|---|---|---|---|---|
| Benefit Type | Incremental Daily Benefit Amount for the First X Days | Ultimate Daily Benefit Amount | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 |
| ☑ Hospital Indeminity Plan: | 200 | 50 | 92.50 | 149.20 | 180.38 | 290.94 | 246.67 | 360.07 |
| ☑ Strike Waiver: | | | - | - | - | - | - | - |
| ☑ Ambulance Benefit: | 50 | | 5.00 | 7.10 | 9.75 | 13.85 | 15.00 | 19.20 |
| ☑ Wellness Benefit: | 25 | | 18.00 | 24.00 | 35.10 | 46.80 | 54.00 | 66.00 |
| Total Cost | | | 115.50 | 180.30 | 225.23 | 351.59 | 315.67 | 445.27 |

| **Level #2** | | | **Individual Plan- Annual Premium** | | **Individual Plus One- Annual Premium** | | **Family Plan- Annual Premium** | |
|---|---|---|---|---|---|---|---|---|
| Benefit Type | Incremental Daily Benefit Amount for the First X Days | Ultimate Daily Benefit Amount | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 |
| ☑ Hospital Indeminity Plan: | 300 | 100 | 160.80 | 268.40 | 313.56 | 523.38 | 428.80 | 644.00 |
| ☑ Strike Waiver: | | | - | - | - | - | - | - |
| ☑ Ambulance Benefit: | 100 | | 10.00 | 14.20 | 19.50 | 27.69 | 30.00 | 38.40 |
| ☑ Wellness Benefit: | 50 | | 36.00 | 48.00 | 70.20 | 93.60 | 108.00 | 132.00 |
| ☑ Outpatient Surgery: | 100 | | 17.77 | 42.00 | 34.64 | 81.90 | 47.38 | 95.84 |
| Total Cost | | | 224.57 | 372.60 | 437.90 | 726.57 | 614.18 | 910.24 |

| **Level #3** | | | **Individual Plan- Annual Premium** | | **Individual Plus One- Annual Premium** | | **Family Plan- Annual Premium** | |
|---|---|---|---|---|---|---|---|---|
| Benefit Type | Incremental Daily Benefit Amount for the First X Days | Ultimate Daily Benefit Amount | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 |
| ☑ Hospital Indeminity Plan: | 400 | 100 | 185.00 | 298.40 | 360.75 | 581.88 | 493.33 | 720.13 |
| ☑ Strike Waiver: | | | - | - | - | - | - | - |
| ☑ Ambulance Benefit: | 100 | | 10.00 | 14.20 | 19.50 | 27.69 | 30.00 | 3.20 |
| ☑ Wellness Benefit: * | 75 | | 54.00 | 72.00 | 105.30 | 140.40 | 13.50 | 198.00 |
| ☑ Outpatient Surgery: | 100 | | 17.77 | 42.00 | 34.64 | 81.90 | 47.38 | 95.84 |
| **CRITICAL EVENT*** | | | | | | | | |
| ☑ Critical Event* | 1,000 | | 78.74 | 134.23 | 153.54 | 261.74 | 209.97 | 320.94 |
| Total Cost | | | 345.51 | 560.83 | 673.74 | 1,093.61 | 794.18 | 1,338.12 |

* Benefits are lump sum payouts for Cancer, Heart Attack, Stroke, Paralysis and Hospital Accidental Injury

Rates ULL-HIP-1010
Incremental Benefit Days: 3

## Appendix A.1

| | |
|---|---|
| **Premium Payment Mode:** | Annual |
| **Incremental Benefit Days:** | |

| **Level #1** | | | **Individual Plan- Annual Premium** | | **Individual Plus One- Annual Premium** | | **Family Plan- Annual Premium** | |
|---|---|---|---|---|---|---|---|---|
| Benefit Type | Incremental Daily Benefit Amount for the First X Days | Ultimate Daily Benefit Amount | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 |
| ☑ Hospital Indeminity Plan: | 200 | 50 | 120.90 | 190.00 | 235.76 | 370.50 | 322.40 | 460.60 |
| ☑ Strike Waiver: | | | - | - | - | - | - | - |
| ☑ Ambulance Benefit: | 50 | | 5.00 | 7.10 | 9.75 | 13.85 | 15.00 | 19.20 |
| ☑ Wellness Benefit: | 25 | | 18.00 | 24.00 | 35.10 | 46.80 | 54.00 | 66.00 |
| Total Cost | | | 143.90 | 221.10 | 280.61 | 431.15 | 391.40 | 545.80 |

| **Level #2** | | | **Individual Plan- Annual Premium** | | **Individual Plus One- Annual Premium** | | **Family Plan- Annual Premium** | |
|---|---|---|---|---|---|---|---|---|
| Benefit Type | Incremental Daily Benefit Amount for the First X Days | Ultimate Daily Benefit Amount | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 |
| ☑ Hospital Indeminity Plan: | 300 | 100 | 203.40 | 329.60 | 396.63 | 642.72 | 542.40 | 794.80 |
| ☑ Strike Waiver: | | | - | - | - | - | - | - |
| ☑ Ambulance Benefit: | 100 | | 10.00 | 14.20 | 19.50 | 27.69 | 30.00 | 38.40 |
| ☑ Wellness Benefit: | 50 | | 36.00 | 48.00 | 70.20 | 93.60 | 108.00 | 132.00 |
| ☑ Outpatient Surgery: | 100 | | 17.77 | 42.00 | 34.64 | 81.90 | 47.38 | 95.84 |
| Total Cost | | | 267.17 | 433.80 | 520.97 | 845.91 | 727.78 | 1,061.04 |

| **Level #3** | | | **Individual Plan- Annual Premium** | | **Individual Plus One- Annual Premium** | | **Family Plan- Annual Premium** | |
|---|---|---|---|---|---|---|---|---|
| Benefit Type | Incremental Daily Benefit Amount for the First X Days | Ultimate Daily Benefit Amount | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 |
| ☑ Hospital Indeminity Plan: | 400 | 100 | 241.80 | 380.00 | 471.51 | 741.00 | 644.80 | 921.20 |
| ☑ Strike Waiver: | | | - | - | - | - | - | - |
| ☑ Ambulance Benefit: | 100 | | 10.00 | 14.20 | 19.50 | 27.69 | 30.00 | 3.20 |
| ☑ Wellness Benefit: * | 75 | | 54.00 | 72.00 | 105.30 | 140.40 | 13.50 | 198.00 |
| ☑ Outpatient Surgery: | 100 | | 17.77 | 42.00 | 34.64 | 81.90 | 47.38 | 95.84 |
| **CRITICAL EVENT*** | | | | | | | | |
| ☑ Critical Event* | 1,000 | | 78.74 | 134.23 | 153.54 | 261.74 | 209.97 | 320.94 |
| Total Cost | | | 402.31 | 642.43 | 784.50 | 1,252.73 | 945.65 | 1,539.19 |

* Benefits are lump sum payouts for Cancer, Heart Attack, Stroke, Paralysis and Hospital Accidental Injury

Rates ULL-HIP-1010
Incremental Benefit Days: 4

## Appendix A.1

| | |
|---|---|
| **Premium Payment Mode:** | Annual |
| **Incremental Benefit Days:** | |

| **Level #1** | | | **Individual Plan- Annual Premium** | | **Individual Plus One- Annual Premium** | | **Family Plan- Annual Premium** | |
|---|---|---|---|---|---|---|---|---|
| Benefit Type | Incremental Daily Benefit Amount for the First X Days | Ultimate Daily Benefit Amount | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 |
| ☑ Hospital Indeminity Plan: | 200 | 50 | 126.10 | 200.00 | 245.90 | 390.00 | 336.27 | 484.07 |
| ☑ Strike Waiver: | | | - | - | - | - | - | - |
| ☑ Ambulance Benefit: | 50 | | 5.00 | 7.10 | 9.75 | 13.85 | 15.00 | 19.20 |
| ☑ Wellness Benefit: | 25 | | 18.00 | 24.00 | 35.10 | 46.80 | 54.00 | 66.00 |
| Total Cost | | | 149.10 | 231.10 | 290.75 | 450.65 | 405.27 | 569.27 |

| **Level #2** | | | **Individual Plan- Annual Premium** | | **Individual Plus One- Annual Premium** | | **Family Plan- Annual Premium** | |
|---|---|---|---|---|---|---|---|---|
| Benefit Type | Incremental Daily Benefit Amount for the First X Days | Ultimate Daily Benefit Amount | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 |
| ☑ Hospital Indeminity Plan: | 300 | 100 | 211.20 | 344.60 | 411.84 | 671.97 | 563.20 | 830.00 |
| ☑ Strike Waiver: | | | - | - | - | - | - | - |
| ☑ Ambulance Benefit: | 100 | | 10.00 | 14.20 | 19.50 | 27.69 | 30.00 | 38.40 |
| ☑ Wellness Benefit: | 50 | | 36.00 | 48.00 | 70.20 | 93.60 | 108.00 | 132.00 |
| ☑ Outpatient Surgery: | 100 | | 17.77 | 42.00 | 34.64 | 81.90 | 47.38 | 95.84 |
| Total Cost | | | 274.97 | 448.80 | 536.18 | 875.16 | 748.58 | 1,096.24 |

| **Level #3** | | | **Individual Plan- Annual Premium** | | **Individual Plus One- Annual Premium** | | **Family Plan- Annual Premium** | |
|---|---|---|---|---|---|---|---|---|
| Benefit Type | Incremental Daily Benefit Amount for the First X Days | Ultimate Daily Benefit Amount | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 |
| ☑ Hospital Indeminity Plan: | 400 | 100 | 252.20 | 400.00 | 491.79 | 780.00 | 672.53 | 968.13 |
| ☑ Strike Waiver: | | | - | - | - | - | - | - |
| ☑ Ambulance Benefit: | 100 | | 10.00 | 14.20 | 19.50 | 27.69 | 30.00 | 3.20 |
| ☑ Wellness Benefit: * | 75 | | 54.00 | 72.00 | 105.30 | 140.40 | 13.50 | 198.00 |
| ☑ Outpatient Surgery: | 100 | | 17.77 | 42.00 | 34.64 | 81.90 | 47.38 | 95.84 |
| **CRITICAL EVENT*** | | | | | | | | |
| ☑ Critical Event* | 1,000 | | 78.74 | 134.23 | 153.54 | 261.74 | 209.97 | 320.94 |
| Total Cost | | | 412.71 | 662.43 | 804.78 | 1,291.73 | 973.38 | 1,586.12 |

* Benefits are lump sum payouts for Cancer, Heart Attack, Stroke, Paralysis and Hospital Accidental Injury

Rates ULL-HIP-1010
Incremental Benefit Days: 5

## Appendix A.1

| | |
|---|---|
| **Premium Payment Mode:** | Annual |
| **Incremental Benefit Days:** | |

| **Level #1** | | | **Individual Plan- Annual Premium** | | **Individual Plus One- Annual Premium** | | **Family Plan- Annual Premium** | |
|---|---|---|---|---|---|---|---|---|
| Benefit Type | Incremental Daily Benefit Amount for the First X Days | Ultimate Daily Benefit Amount | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 |
| ☑ Hospital Indeminity Plan: | 200 | 50 | 153.70 | 253.60 | 299.72 | 494.52 | 409.87 | 609.67 |
| ☑ Strike Waiver: | | | - | - | - | - | - | - |
| ☑ Ambulance Benefit: | 50 | | 5.00 | 7.10 | 9.75 | 13.85 | 15.00 | 19.20 |
| ☑ Wellness Benefit: | 25 | | 18.00 | 24.00 | 35.10 | 46.80 | 54.00 | 66.00 |
| Total Cost | | | 176.70 | 284.70 | 344.57 | 555.17 | 478.87 | 694.87 |

| **Level #2** | | | **Individual Plan- Annual Premium** | | **Individual Plus One- Annual Premium** | | **Family Plan- Annual Premium** | |
|---|---|---|---|---|---|---|---|---|
| Benefit Type | Incremental Daily Benefit Amount for the First X Days | Ultimate Daily Benefit Amount | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 |
| ☑ Hospital Indeminity Plan: | 300 | 100 | 252.60 | 425.00 | 492.57 | 828.75 | 673.60 | 1,018.40 |
| ☑ Strike Waiver: | | | - | - | - | - | - | - |
| ☑ Ambulance Benefit: | 100 | | 10.00 | 14.20 | 19.50 | 27.69 | 30.00 | 38.40 |
| ☑ Wellness Benefit: | 50 | | 36.00 | 48.00 | 70.20 | 93.60 | 108.00 | 132.00 |
| ☑ Outpatient Surgery: | 100 | | 17.77 | 42.00 | 34.64 | 81.90 | 47.38 | 95.84 |
| Total Cost | | | 316.37 | 529.20 | 616.91 | 1,031.94 | 858.98 | 1,284.64 |

| **Level #3** | | | **Individual Plan- Annual Premium** | | **Individual Plus One- Annual Premium** | | **Family Plan- Annual Premium** | |
|---|---|---|---|---|---|---|---|---|
| Benefit Type | Incremental Daily Benefit Amount for the First X Days | Ultimate Daily Benefit Amount | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 | Age 18 to 44 | Age 45 to 65 |
| ☑ Hospital Indeminity Plan: | 400 | 100 | 307.40 | 507.20 | 599.43 | 989.04 | 819.73 | 1,219.33 |
| ☑ Strike Waiver: | | | - | - | - | - | - | - |
| ☑ Ambulance Benefit: | 100 | | 10.00 | 14.20 | 19.50 | 27.69 | 30.00 | 3.20 |
| ☑ Wellness Benefit: * | 75 | | 54.00 | 72.00 | 105.30 | 140.40 | 13.50 | 198.00 |
| ☑ Outpatient Surgery: | 100 | | 17.77 | 42.00 | 34.64 | 81.90 | 47.38 | 95.84 |
| **CRITICAL EVENT*** | | | | | | | | |
| ☑ Critical Event* | 1,000 | | 78.74 | 134.23 | 153.54 | 261.74 | 209.97 | 320.94 |
| Total Cost | | | 467.91 | 769.63 | 912.42 | 1,500.77 | 1,120.58 | 1,837.32 |

* Benefits are lump sum payouts for Cancer, Heart Attack, Stroke, Paralysis and Hospital Accidental Injury

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

**Note To Filer**

**Created By:**
Rosalind Minor on 12/08/2010 12:48 PM
**Last Edited By:**
Rosalind Minor
**Submitted On:**
12/30/2010 12:13 PM
**Subject:**
Your response on 12/8/10
**Comments:**

Thank you for your response to my objection letter.

You state that the forms have been revised, but you did not replace the old forms with the new forms reflecting the changes.

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

# Form Schedule

**Lead Form Number:**

| Schedule Item Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|---|---|---|---|---|---|---|---|
| Approved-Closed 12/30/2010 | ULLR-WELL-1010 | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | Wellness Benefit Rider | Initial | | 50.700 | ULLR-WELL-1010.pdf |
| Approved-Closed 12/30/2010 | ULLR-AMB-1010 | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | Ambulance Benefit Rider | Initial | | 54.700 | ULLR-AMB-1010.pdf |
| Approved-Closed 12/30/2010 | ULLR-SURG-1010 | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | Outpatient Surgery Benefit Rider | Initial | | 52.500 | ULLR-SURG-1010.pdf |
| Approved-Closed 12/30/2010 | ULLR-CRIT-1010 | Policy/Contract/Fraternal Certificate: | Critical Event Benefit Rider | Initial | | 52.600 | ULLR-CRIT-1010.pdf |

| | | | | | | |
|---|---|---|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | | *State:* | *Arkansas* | | |
| *Filing Company:* | *The Union Labor Life Insurance Company* | | *State Tracking Number:* | *47427* | | |
| *Company Tracking Number:* | *ULL-HIP-1010* | | | | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* | | |
| *Product Name:* | *ULL-HIP-1010* | | | | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | | | | |
| | | Amendment, Insert Page, Endorsement or Rider | | | | |
| Approved-Closed 12/30/2010 | ULLA-HIP-1010 | Application/Enrollment Form | Enrollment Form | Initial | 50.800 | ULLA-HIP-1010.pdf |
| Approved-Closed 12/30/2010 | ULL-HIP-1010 AR | Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider | Supplemental Hospital Indemnity Insurance Policy | Initial | 50.200 | ULL-HIP-1010 AR.pdf |

# The Union Labor Life Insurance Company

**("We, Us, Our, the Company")**
**[Administrative Office: 8403 Colesville Road, Silver Spring, MD 20910**
**Executive Office: 1625 Eye Street N.W., Washington DC 20006]**

## WELLNESS BENEFIT RIDER

This rider is a part of the policy to which it is attached. It is issued in consideration of the Policyholder's application for this coverage and payment of any required premium.

The effective date of this rider is the date shown in the policy Schedule.

### WELLNESS BENEFIT

We will pay the Wellness Benefit as shown on the Schedule when the Insured receives the following services during an office visit to a Physician: (1) eye examination performed by an optometrist or ophthalmologist; (2) dental examination; or (3) preventive health services as defined by Section 2713 (29 CFR 2590.715-2713) of the Patient Protection and Affordable Care Act (PPACA).

Preventive health services as defined in PPACA include: (1) evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved; (2) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; (3) evidence-based preventive care and screenings for Covered Dependent children as provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and (4) with respect to women, additional preventive care and screenings not described above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

**Incontestability.** We will not contest this rider after it has been in force during the Insured's lifetime for two years from its effective date, except for fraud in the procurement of the policy, when permitted by applicable law in the state where the policy is delivered or issued for delivery.

The statement on which the contest is based will be material to the risk accepted or the hazard assumed by Us.

With respect to a reinstated rider, the contestable period will begin with the day of reinstatement, and will be based only on statements in the reinstatement application, unless the original contestable period has not yet expired.

**Reinstatement.** If the Insured's policy lapses, and is reinstated, this rider may be reinstated.

**Right To Adjust Rider Rates.** We reserve the right to change the Rider rates on the same terms as described in the Policy.

**Termination of Rider.** The benefit provided by this rider will end on the earliest of the following dates:
1. the date the policy ends; or
2. the date the 31 day Grace Period ends, if the Insured fails to pay any premium when due.

Benefits are subject to all terms and limitations of the policy. This rider does not waive, alter or extend any provisions or conditions of the policy except to the extent shown above.

[officer signature] [officer signature]

# The Union Labor Life Insurance Company

**("We, Us, Our, the Company")**
**[Administrative Office: 8403 Colesville Road, Silver Spring, MD 20910**
**Executive Office: 1625 Eye Street N.W., Washington DC 20006]**

## AMBULANCE BENEFIT RIDER

This rider is a part of the policy to which it is attached. It is issued in consideration of the Policyholder's application for this coverage and payment of any required premium.

The effective date of this rider is the date shown in the policy Schedule.

### AMBULANCE BENEFIT

We will pay the Ambulance Benefit as shown on the Schedule if a licensed surface or air ambulance service transports the Insured to or from a Hospital where the Insured is confined as an inpatient due to Sickness or Injury, including transportation from one medical facility to another when necessary. Any ambulance service must be necessary to protect the Insured's health and safety when other reasonable and customary travel methods are not available. The ambulance service must be provided while the Policy and this Rider are in force.

**Incontestability.** We will not contest this rider after it has been in force during the Insured's lifetime for two years from its effective date, except for fraud in the procurement of the policy, when permitted by applicable law in the state where the policy is delivered or issued for delivery.

The statement on which the contest is based will be material to the risk accepted or the hazard assumed by Us.

With respect to a reinstated rider, the contestable period will begin with the day of reinstatement, and will be based only on statements in the reinstatement application, unless the original contestable period has not yet expired.

**Reinstatement.** If the Insured's policy lapses, and is reinstated, this rider may be reinstated.

**Right To Adjust Rider Rates.** We reserve the right to change the Rider rates on the same terms as described in the Policy.

**Termination of Rider.** The benefit provided by this rider will end on the earliest of the following dates:
1. the date the policy ends; or
2. the date the 31 day Grace Period ends, if the Insured fails to pay any premium when due.

Benefits are subject to all terms and limitations of the policy. This rider does not waive, alter or extend any provisions or conditions of the policy except to the extent shown above.

[officer signature] [officer signature]

# The Union Labor Life Insurance Company

**("We, Us, Our, the Company")**
**[Administrative Office: 8403 Colesville Road, Silver Spring, MD 20910**
**Executive Office: 1625 Eye Street N.W., Washington DC 20006]**

## OUTPATIENT SURGERY BENEFIT RIDER

This rider is a part of the policy to which it is attached. It is issued in consideration of the Policyholder's application for this coverage and payment of any required premium.

The effective date of this rider is the date shown in the policy Schedule.

### OUTPATIENT SURGERY BENEFIT

We will pay the Outpatient Benefit as shown on the Schedule if the Insured receives Outpatient Surgery as a result of an Injury or Sickness. To be eligible for this benefit:
(1) The Outpatient Surgery must be Medically Necessary and recommended by a Physician;
(2) The Insured must be covered under the Policy and this Rider at the time of the Outpatient Surgery; and
(3) The Insured must not be admitted to a Hospital as an inpatient as a result of that same Injury or Sickness.

Only one benefit amount is payable per Insured in any calendar day.

**Outpatient Surgery** means an Injury or Sickness that requires an outpatient surgical procedure. The surgical procedure must be performed in an emergency room, trauma center, urgent care center, hospital outpatient facility or free standing surgical facility. Cataract surgery is also covered when performed in a Physician's office.

### Exclusions

This Rider does not pay a benefit for the following:

1. A Pre-Existing Condition as described in the Policy; or

2. Any outpatient treatments or surgeries for which the principal function is one of the following: (a) injections; (b) dental procedures; (c) dermatology procedures; (d) sutures removal; or (e) chemotherapy or radiological procedures.

Any other Exclusions listed in the Policy also apply to this Rider.

**Incontestability.** We will not contest this rider after it has been in force during the Insured's lifetime for two years from its effective date, except for fraud in the procurement of the policy, when permitted by applicable law in the state where the policy is delivered or issued for delivery.

The statement on which the contest is based will be material to the risk accepted or the hazard assumed by Us.

With respect to a reinstated rider, the contestable period will begin with the day of reinstatement, and will be based only on statements in the reinstatement application, unless the original contestable period has not yet expired.

**Reinstatement.** If the Insured's policy lapses, and is reinstated, this rider may be reinstated.

**Right To Adjust Rider Rates.** We reserve the right to change the Rider rates, on a class basis, on the same terms as described in the Policy.

**Termination of Rider.** The benefit provided by this rider will end on the earliest of the following dates:

1. the date the policy ends; or
2. the date the 31 day Grace Period ends, if the Insured fails to pay any premium when due.

Benefits are subject to all terms and limitations of the policy. This rider does not waive, alter or extend any provisions or conditions of the policy except to the extent shown above.

[officer signature] [officer signature]

# The Union Labor Life Insurance Company

**("We, Us, Our, the Company")**
**[Administrative Office: 8403 Colesville Road, Silver Spring, MD 20910**
**Executive Office: 1625 Eye Street N.W., Washington DC 20006]**

## CRITICAL EVENT BENEFIT RIDER

This Rider is a part of the policy to which it is attached. It is issued in consideration of the Policyholder's application for this coverage and payment of any required premium.

The effective date of this rider is the Policy Date shown in the policy Schedule.

### CRITICAL EVENT BENEFIT

We will pay the Critical Event Benefit as shown on the Schedule if the Insured experiences the following event:
(1) Diagnosis of cancer;
(2) Stroke;
(3) Heart attack;
(4) Onset of irreversible Paralysis; or
(5) Hospital Confinement due to a Workplace Accident;

while the Policy and this Rider are in force. In each category (1)-(5) above, the benefit will be paid only once per Insured.

### Definitions

**Cancer** means a disease manifested by the presence of a malignant tumor that is characterized by the uncontrolled growth and spread of malignant cells that invade tissue, blood or the lymphatic system. This includes leukemia and Hodgkins Disease. Cancer also means a malignant tumor that is confined to the site of origin, the cells of which have not invaded neighboring tissue. Cancer must be diagnosed by a Physician. The diagnosis shall include microscopic examination of tissue or preparations from the blood system and other pertinent clinical findings. Premalignant (precancerous) conditions or conditions with malignant potential are not considered a Cancer.

**Heart Attack** means acute myocardial infarction, coronary thrombosis or coronary occlusion which is diagnosed by a Physician. The diagnosis shall include electrocardiographic (EKG) evidence and other pertinent clinical findings. Other heart disease or other abnormality of the heart or cardiovascular system is not considered a Heart Attack.

**Paralysis** means the total and irreversible loss of voluntary movement of one or more arms or legs.. Paralysis must persist for twelve (12) consecutive months to be considered irreversible for the purpose of this benefit. Loss due to severance of the limb from the body is not paralysis.

**Stroke** means a cerebral vascular accident, cerebral thrombosis, cerebral embolism, cerebral hemorrhage, or ruptured cerebral aneurysm which is diagnosed by a Physician. Such diagnosis shall include electroencephalography (EEG) and other pertinent clinical findings. The following are not considered a Stroke: (1) any other disease or abnormality of the brain; (2) transient ischemic attack (TIA); or (3) transient cerebral ischemia (TCI).

**Workplace Accident** means an Injury that occurs while the Insured is:
(1) At his workplace and performing his regularly scheduled work; or
(2) Traveling between his residence and his workplace in connection with his regularly scheduled work.

**Incontestability.** We will not contest this rider after it has been in force during the Insured's lifetime for two years from its effective date, except for fraud in the procurement of the policy, when permitted by applicable law in the state where the policy is delivered or issued for delivery.

The statement on which the contest is based will be material to the risk accepted or the hazard assumed by Us.

With respect to a reinstated rider, the contestable period will begin with the day of reinstatement, and will be based only on statements in the reinstatement application, unless the original contestable period has not yet expired.

**Reinstatement.** If the Insured's policy lapses, and is reinstated, this rider may be reinstated.

**Right To Adjust Rider Rates.** We reserve the right to change the Rider rates on the same terms as described in the Policy.

**Termination of Rider.** The benefit provided by this rider will end on the earliest of the following dates:
1. the date the policy ends; or
2. the date the 31 day Grace Period ends, if the Insured fails to pay any premium when due.

Benefits are subject to all terms and limitations of the policy. This rider does not waive, alter or extend any provisions or conditions of the policy except to the extent shown above.

[officer signature] [officer signature]

# The Union Labor Life Insurance Company

**("We, Us, Our, the Company")**
**[Administrative Office: 8403 Colesville Road, Silver Spring, MD 20910**
**Executive Office: 1625 Eye Street N.W., Washington DC 20006]**

## ENROLLMENT FORM FOR [SUPPLEMENTAL HOSPITAL INDEMNITY INSURANCE]

[**PLAN 1** ☐ $200 Hospital Indemnity Insurance **PLAN 2** ☐ $300 Hospital Indemnity Insurance

**PLAN 3** ☐ $400 Hospital Indemnity Insurance

| **The following additional benefits are included for each Plan as noted:** | **Plan 1** | **Plan 2** | **Plan 3** |
|---|---|---|---|
| Labor Dispute Waiver of Premium Benefit | X | X | X |
| Wellness Benefit | X | X | X |
| Ambulance Benefit | X | X | X |
| Outpatient Surgery Benefit | | X | X |
| Critical Event Benefit | | | X |

**Check Plans Desired:**

☐ **Individual Plan** *(Principal Insured Only)*

☐ **Individual +1 Plan** *(Principal Insured and Dependent Spouse or Dependent Child*

☐ **Family Plan** (*Principal Insured, Dependent Spouse and/or Dependent Children)]*

**Principal Insured must complete the following (please print):**

Name_____ Daytime Phone # (___) _____
First Middle Initial Last

Address_____ Home Phone # (___) _____
Street or Rd #

Please provide your Email address:

_____
City State Zip _____

Gender: ☐ Male ☐ Female Your Date of Birth:_____
Month Day Year

[Social Security No._____] [Age:_____]

[List all dependents to be covered under the selected Plan: (DO NOT include Principal Insured's name)
*Attach a separate sheet if necessary for additional dependents*

| **Name of Dependent (please print)** | **Relationship** | **Date of Birth** |
|---|---|---|
| 1. | | |
| 2. | | |
| 3. | | |
| 4. | | ] |

[California: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado: It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

Louisiana: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Rhode Island: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Washington: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

For all other states: WARNING: Any person, acting alone or in concert with another, who knowingly and with intent to defraud, injure, or deceive any insurance company submits a claim or application containing any false, deceptive, incomplete or misleading information may be committing a fraudulent insurance act which is a crime and may subject such person to criminal or civil penalties or denial of benefits. ]

Please enroll me in the Plan marked above. I understand that no insurance will be in effect until I am issued my Policy and the required premium is paid. I also understand that a benefit will not be paid for an Injury or Sickness for which I or any person listed above received medical: advice; diagnosis; care; or treatment from a Physician during the six-month period immediately prior to the effective date, until the person has been covered for twelve consecutive months. I understand that I can have only one Policy/Certificate providing the same or similar coverage.

Principal Insured's Signature **X**_____ Date _____

# The Union Labor Life Insurance Company

**("We, Us, Our, the Company")**

**[Administrative Office: 8403 Colesville Road, Silver Spring, MD 20910**
**Executive Office: 1625 Eye Street N.W., Washington DC 20006]**

## SUPPLEMENTAL HOSPITAL INDEMNITY INSURANCE POLICY

This insurance Policy pays benefits in the event of Hospital Confinements due to Sickness and Injury. The Policy is a legal contract. You rely on Us to honor its terms. We depend on Your payment of premium when due. This Policy is issued to the Policyholder. The Policy is issued in consideration of a completed enrollment form and timely payment of the premiums when due. Any payments are subject to all the terms and conditions of this Policy.

This Policy takes effect at 12:01 A.M. Standard Time at Your address on the Policy Effective Date shown on the Policy Schedule. After the first 12 month period, this Policy will automatically renew from year to year for additional 12 month periods subject to the Policy Termination provision. .

**60 Day Right to Examine the Policy:** If You are not satisfied, for any reason, You may return the Policy within 60 days of the date received. When returned, the Policy will be void from the beginning, and any premiums paid will be refunded. The Policy must be returned to Us at Our Administrative Office or to Our authorized producer.

**Pre-Existing Condition Limitation:** We will not pay a benefit for a Pre-existing Condition. Expenses for a Pre-Existing Condition will be eligible after the Insured has been covered for twelve consecutive months. The Pre-Existing Condition Limitation will apply to new Covered Dependents or an increase in benefits on the effective date of the change in coverage, but will not apply to coverage already in force.

**Guaranteed Renewable:** We guarantee to renew this Policy subject to the timely payment of premiums when due. No change will be made in the premium rates unless We make a change on all policies of this form in Your state.

**This is not a Medicare Supplement Policy.** If You are eligible for Medicare, please review the Medicare Supplement Buyer's Guide available from Us.

In Witness, this Policy is signed by the officers below.

[officer signature] [officer signature]

**PARTICIPATING**

**BENEFITS REDUCE AT AGE 70**
**[REDUCED BENEFITS FOR COVERED DEPENDENT CHILDREN]**

**TABLE OF CONTENTS**

## SCHEDULE

**Policyholder:** [John Doe]

**Policy Number** [12345]

**Principal Insured:** [John Doe]

**Policy Delivered In:** [state]

**Dependent Spouse/Domestic Partner:**
[Jane Doe]

**Dependent Children:**
[Mary Doe]

**Policy Effective Date:** [January 1, 2011]

**Premium Due Date:** [January 1, 2011]

**Premium:** [$xx.xx quarterly]

Insurance Benefits are determined by this Schedule and the terms of the Policy.

| **Description of Benefits** | **Benefit Amounts and Limits**<br>(Benefits apply to all Insureds unless otherwise noted) |
|---|---|
| **Hospital Confinement Indemnity Benefit** | [$xxx] daily benefit for the first [3] days in a Policy Year<br>[$xxx] daily benefit after the first [3] days in a Policy Year<br>Maximum of [180] days per Policy Year |
| [**Wellness Benefit** | [$xxx] per visit, up to [1 visit] per Policy Year ] |
| [**Emergency Ambulance Benefit** | [$xxx] per ambulance trip, up to [1 payment] per Policy Year] |
| [**Outpatient Surgery Benefit** | [$xxx] Benefit, up to one payment per calendar day] |
| [**Critical Event Indemnity Benefit** | [$xxx] Benefit, up to one payment per category of covered event] |
| **Labor Dispute Waiver of Premium Benefit** | Premium waived for up to one year during participation in a lawful strike or lock-out. Principal Insured only. |

| **Benefit Percentages** | |
|---|---|
| Adults under age 70 | 100% of the Benefit Amounts |
| Adults age 70 and over | 50% of the Benefit Amounts, except as below<br>100% of the Wellness Benefit |
| [Covered Dependent Children: | 50% of the Benefit Amounts<br>100% of the Wellness Benefit ] |
| *[OR]*<br>[Covered Dependent Child: | 100% of the Benefit Amounts] |

**Termination Age:** None

## DEFINITIONS

When used in this Policy the following words and phrases have the meaning given. The use of any personal pronoun includes both genders.

**Complications of Pregnancy** (which are considered to be a Sickness under this Policy) means conditions arising during pregnancy whose diagnoses are separate from pregnancy but are unfavorably affected by pregnancy or are caused by pregnancy, such as: (1) infections of the genital or urinary tract; (2) acute nephritis; (3) nephrosis; (4) necrosis of the liver or kidney; (5) hypertension; and (6) similar conditions of comparable severity.

Complications of Pregnancy also includes abnormal maternal conditions directly related to and caused by pregnancy, such as: (1) hemorrhage of pregnancy; (2) rupture of uterus; (3) hydatidiform mole; (4) hyperemesis gravidarum; (5) eclampsia; (6) ectopic pregnancy; (7) non-elective caesarean section; and (8) spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy shall not include: (1) false labor; (2) occasional spotting; (3) physician prescribed rest; (4) morning sickness; or (5) other minor conditions associated with normal pregnancy.

**Confined or Confinement** means the Insured is a registered bed patient in a Hospital and is charged room and board by the facility. He must be in the facility on the advice of a Physician and under the regular care and treatment of a Physician. The Confinement must be Medically Necessary for the treatment of the Sickness or Injury.

Confinement does not include treatment received in the outpatient department of the facility.

**Covered Dependent** means any Dependent who is insured.

**Dependent** means: (1) Your lawful spouse (including your Domestic Partner); and (2) Your unmarried child(ren) who are under age 19 (or under age 25 if enrolled as a full-time student in an accredited post secondary school, college, or vocational or technical school). The child(ren) must be primarily dependent on You for support and maintenance.

Newborn children are covered from the moment of birth. Your adopted child is covered from the earlier of: (a) the moment the adoption is recognized as legal by Your home state; or (b) the date coverage is required to start by the laws of Your home state.

A newborn or adopted child is a Covered Dependent for 31 days. Coverage then stops unless You: (a) send Us a written request to continue coverage; and (b) pays any required additional premium.

**Domestic Partner** means the domestic partner of the Principal Insured, for whom we have been furnished and accepted proof:

a. of financial interdependence such as joint bank accounts, joint credit cards, jointly owned property and beneficiary designations for life insurance or pension plans;
b. of co-habitation;
c. of a prior relationship of a least 6 months, with an expectation of a future commitment;
d. of attainment of the age of majority;
e. that neither the Principal Insured or the domestic partner are legally married;
f. that the Principal Insured is not related by blood to the domestic partner; and
g. of filing as domestic partners, if the Principal Insured is a resident of a city, municipality or other governing jurisdiction that allows for filing as domestic partners.

The Principal Insured is responsible for notifying us upon dissolution of the domestic partnership and of any change in the status of the proof furnished to us evidencing the domestic partnership.

**Hospital** means an institution which meets all of the following requirements: (1) it must be operated according to law; (2) it must give 24 hour medical care, diagnosis and treatment to the sick or injured on an Inpatient basis for which a charge is made; (3) it must provide diagnostic and surgical facilities supervised by Physicians; (4) Registered Nurses must be on 24 hour call or duty; and (5) the care must be given either on the Hospital's premises or in facilities available to the Hospital on a pre-arranged basis.

Except as specifically provided by this Policy or state law, the term Hospital does not include a facility, or part of a facility or Hospital, which is licensed as and providing care primarily as: (1) a rest facility, nursing facility, convalescent facility, or facility for the aged; (2) a chronic or skilled nursing facility, extended care facility, or a rehabilitation facility; or (3) a facility or program for treatment of mental illness, behavioral problems, or alcohol or drug abuse.

**Immediate Family** means Your spouse, Domestic Partner, child(ren), parents, brother(s), sister(s), in-laws or any member of Your household.

**Injury** means bodily Injury caused by an accident. It must be sustained by the Insured while coverage is in force. The Injury must be the direct cause of Loss and must be independent of all other causes. The Injury must not be caused by or contributed to by Sickness.

**Inpatient** means a registered bed patient Confined in a Hospital.

**Insured** means the Principal Insured and each Covered Dependent.

**Loss** means the Hospital Confinement of an Insured. Loss also means the occurrence of any other event for which benefits are payable under this Policy.

**Medically Necessary** means care, services, supplies, or treatment ordered by a Physician for the diagnosis or treatment of a Sickness or Injury. To be Medically Necessary, the care, services, or supplies must: (1) be appropriate and necessary for the symptoms, diagnosis or treatment, of the Insured's condition, disease, ailment, or Injury; (2) be provided for the diagnosis or direct care of the Insured's medical condition; (3) be in accordance with standards of good medical practice accepted by the organized medical community; (4) not be primarily for the convenience and/or comfort of the Insured, his family, his Physician or another provider of services; and (5) not be experimental or investigational.

In addition, Medically Necessary means care that is reasonable, necessary, and not custodial. Care is considered to be custodial when its primary purpose is to meet activities of daily living that could be met by persons other than Physicians and Nurses.

**Mental Disease or Disorder** means neurosis; psychoneurosis; psychopathy; psychosis; or mental or emotional disease or disorder of any kind without a demonstrable organic cause.

**Nurse** means Registered Graduate Nurse (R.N.), Licensed Practical Nurse (L.P.N.), or Licensed Vocation Nurse (L.V.N.). A Nurse may not be You or a member of Your Immediate Family.

**Physician** means a licensed physician or other practitioner who is practicing within the scope of his license for the service or treatment provided. Neither You nor any member of Your Immediate Family will be considered a Physician.

**Policy Year** means each continuous 12-month period the policy is in force beginning from the Policy Effective Date.

**Pre-Existing Condition** means a condition for which medical: advice; diagnosis; care; or treatment was recommended by or received from a Physician during the six-month period immediately prior to the Insured's Effective Date of coverage. Pregnancy is not a Pre-Existing Condition.

**Premium** means the payment made for coverage.

**Principal Insured** means the person who enrolled for coverage and who is named as the "Principal Insured."

**Sickness** means an illness, disease, or physical condition which first manifests while the Insured is covered under the Policy. It also includes Complications of Pregnancy.

**We, Our and Us** means The Union Labor Life Insurance Company.

**You, Your, and Yours** means the Principal Insured.

## EFFECTIVE DATE OF INSURANCE

**Principal Insured:** The coverage takes effect at 12:01 A.M., Standard Time, at Your home on the Effective Date. Before coverage takes effect, You must enroll and pay the required premium. If no premium is required at time of enrollment, the first premium is due within 21 days of the Effective Date. Failure to pay the premium will void coverage from the Effective Date and no benefits will be paid.

**Dependent:** You may insure any Dependent on the later of: (a) the Effective Date; or (2) the date a Dependent is acquired.

If an Insured is Confined in a Hospital or an institution which provides medical care and treatment on the date his insurance would otherwise become effective, he will be insured the day following formal Hospital or institution discharge.

**Changes in Coverage:** To add a Dependent, You must: (a) send Us a written request; and (b) pay any required additional premium.

The effective date for any additional Dependents will be the date shown on Our endorsement or change form.

If a new eligible Dependent is added or if the change request increases the amount of coverage or adds new benefits, the Effective Date of insurance will be deferred if the Dependent is Confined in a Hospital or an institution which provides medical care and treatment on the date the insurance would otherwise become effective. The change will be effective the day following formal discharge from the Hospital or institution. This does apply to newborn children.

## HOSPITAL CONFINEMENT INDEMNITY BENEFIT

We will pay the benefit shown on the Schedule when We receive satisfactory proof of Loss that, as a result of a covered Injury or Sickness as defined in the Policy, the Insured is Confined in a Hospital as an Inpatient. The Confinement must begin while the Insured is covered under this Policy.

Benefits will be paid from the first day of Hospital Confinement and will continue for as long as the Insured is Confined for such Injury or Sickness, up to the maximum shown on the Schedule.

## LABOR DISPUTE WAIVER OF PREMIUM BENEFIT

We will waive premiums for the policy and any attached riders if the Principal Insured is Actively at Work and:
1. Participating in a lawful strike authorized by the Principal Insured's labor union; or
2. Locked-out of his or her place of employment as a result of a labor dispute between the Principal Insured's labor union and employer.

The premium to be waived for the premium period is:
1. The premium amount shown in the Schedule; plus
2. The cost for additional benefits provided by a rider, if any.

"Actively at Work" means the Principal Insured is performing all the regular duties of his or her occupation at the time the strike or lock-out begins.

This benefit begins on the next premium due date after the 30-day period immediately following the start of the strike or lock-out. We must receive at Our Administrative Office written notice and satisfactory proof to Us of the strike or lock-out. We must receive such notice and proof before benefits begin. This rider must be in force before the date the strike or lock-out begins. The Principal Insured must be a member in good standing. The Principal Insured must also be Actively at Work with the employer at the beginning of the strike. To receive benefits under this rider, satisfactory proof of the status of the strike or lock-out must be given Us when and as often as We may reasonably require, but in no event less than every 30 days.

We will stop providing benefits if proof of status is not provided as required. We must also be notified as soon as:
1. The strike or lock-out is resolved;
2. The Principal Insured returns to work or is offered the opportunity to return to work for his or her employer; or
3. The Principal Insured's employment is terminated.

Benefits end and premiums will again begin on the earliest of the following dates:
1. One year from the date benefits under this Rider began;
2. The next premium due date following the date the strike or lock-out is resolved;
3. The next premium due date following the date the Principal Insured returns to work or is offered the opportunity to return to work for his or her employer; or
4. The next premium due date following the date the Principal Insured's employment is terminated.

## EXCLUSIONS

Benefits will not be paid under this Policy for Hospital Confinements caused by, resulting from or contributed to by:
1. Injuries resulting from active military service; any active participation in a riot; armed conflict, or insurrection;
2. Declared or undeclared war or any act of war;
3. The use or taking of any narcotic, barbiturate, or any other drug by the Insured unless administered in a therapeutic dosage as prescribed by a Physician;
4. An Injury that occurs while the Insured has a blood alcohol level of .08 (by weight or volume) or higher;
5. Treatment of a Mental Disease or Disorder, alcoholism or drug addiction;
6. Pregnancy or childbirth (Complications of Pregnancy are covered on the same basis as Sickness);
7. Any Confinement rendered in a Hospital which does not comply with the Hospital definition (e.g. nursing facility, convalescent facility, or rehabilitation facility, etc. are not covered);
8. Any rehabilitative care in a Hospital;
9. Suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane;
10. Expenses incurred or care received outside of the United States beyond a period of 14 days of Hospital Confinement; or
11. An Injury that occurs while the Insured is committing an assault or felony.

## TERMINATION OF INSURANCE

If premium is not paid by the due date or during the 31 day Grace Period, coverage for all Insureds stops at the end of the Grace Period.

Dependent spouse or Domestic Partner coverage will end on the premium due date after a change in marital status. The Dependent spouse or Domestic Partner may apply for his own Policy. We must receive a written request within 60 days of the change in marital status. The spouse or Domestic Partner then pays the premium for individual coverage.

A Dependent child's coverage will end upon the earliest of the following: (a) marriage; (b) cessation of eligibility as a Dependent; or (c) attainment of age 19 (or age 25 if enrolled as a full-time student in an accredited post secondary school, college, or vocational or technical school).

If one of these events occurs, the Covered Dependent child may apply for his own Policy. We must receive a written request within 60 days of the date coverage stops. The child then pays the premium for individual coverage.

**Principal Insured's Death:** If coverage terminates due to Your death, the Covered Dependent spouse or Domestic Partner, if any, becomes the Principal Insured. Coverage may continue for any Dependent Children covered at the time of Your death. No evidence of insurability is needed. The spouse or Domestic Partner must provide Us with written notice of Your death within 60 days after the date of death. Premiums will be adjusted if necessary.

However, if there is no surviving spouse or Domestic Partner at the time of Your death, coverage for Dependent Children will end.

## EXTENSION OF BENEFITS

If an Insured's coverage terminates, for any reason except non-payment of premium, while the Insured is Hospital Confined, the Insured will be eligible for benefits for that Hospital Confinement just as if coverage had not ended.

No additional premium is needed for the extended benefit period after termination of coverage.

## HOW TO PAY THE PREMIUM

**Premium Payments:** You keep coverage in force by paying the premiums. The first premium is due prior to the Effective Date. After that, premiums are due on the first day of each renewal period.

**Grace Period:** You have a Grace Period of 31 days after the due date to pay the premium. The coverage stays in force if premium is paid during this Grace Period. If premium is not paid within this Grace Period, his coverage will lapse.

**Reinstatement of Coverage:** If an Insured's premium is not paid before the Grace Period ends, his coverage will lapse. Later acceptance of premium (by Us or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate his coverage. We may require an application for reinstatement. If so, the Insured will be given a conditional receipt for the premium. When the application is approved, the coverage will be reinstated as of the approval date. Lacking such approval, the coverage will be reinstated on the 45th day after the date of the conditional receipt unless We have previously written the Insured of Our disapproval. The reinstatement will cover only Loss due to an Injury sustained after the date of reinstatement; or to a Sickness that begins more than 10 days from the reinstatement date. In all other respects Our rights and the rights of the Insured will remain the same.

**Unpaid Premium:** When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

**Right To Adjust Premium Rates:** We may change rates, by class, on any premium due date. We will provide written notice at least 31 days before the date of change.

## HOW TO FILE A CLAIM

**Notice of Claim:** Written notice of claim, satisfactory to Us, must be given within 30 days after a covered Loss starts, or as soon as reasonably possible. The notice must include the Insured’s name and the Policy Number.

**Claim Forms:** When We receive a notice of claim, We will send forms for filing Proof of Loss. If the forms are not sent within fifteen days, the Insured should submit a written statement of the nature and extent of the Loss. This statement should be submitted within the time noted for Proof of Loss.

**Proof of Loss:** Written Proof of Loss, satisfactory to Us, must be given within 90 days after the Loss or as soon as reasonably possible. In any event, the proof required must be given no later than one year from the time specified unless it was legally impossible to do so.

## CLAIM PAYMENT

**Payment of Claims:** Claims for benefits provided by this Policy will be paid as soon as written Proof of Loss is received. All benefits are paid directly to the Insured, unless directed otherwise. Any benefits unpaid at the Insured's death will be paid to his estate, except that We may pay benefits, up to $1,000 in benefits, to any relative by blood or marriage who We consider to be entitled to the benefits. Any payments We make in good faith will fully discharge Our liability.

**Right to Examine Hospital or Physician Records:** We may, at Our own expense, examine an Insured's Hospital and Physician records as often as necessary while a claim is pending.

**Physical Examination:** At Our expense, We have the right to have the Insured examined as often as reasonably necessary while a claim is pending. We will pay for these expenses.

## OTHER IMPORTANT INFORMATION

**Conformity to Law:** Any provision of this Policy which is in conflict with the laws of the state where the Policy is issued is amended to conform to the laws of that state.

**Dividends:** This is a Participating Policy. While it is in force, it is eligible for dividends as determined by Our Board of Directors. Any dividend will be paid in cash or used to reduce the next premium due.

**Entire Contract:** This Policy, including the endorsements and attached papers, if any, is the entire contract between the parties. No change in this Policy will be effective until approved by one of Our officers. Such approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

**Legal Actions:** No legal action may be brought to recover against this Policy within 60 days after written Proof of Loss has been given. No such action shall be brought after 3 years from the time written Proof of Loss is required.

**Misstatement of Age:** If the Insured's age has been misstated in the enrollment form for insurance, the benefits payable will be those which the premiums paid would have purchased based upon his correct age. There will be an equitable adjustment of premium.

**Other Insurance in this Company:** If You are covered under more than one similar policy or group certificate issued by Us, we may limit the benefits available under the additional policies or certificates. We will return any excess premiums paid under the other policies or group certificates for the same period of coverage.

**Representations:** In the absence of fraud, all statements made by the policyholder or an insured person shall be deemed representations and not warranties, and no statement made for the purpose of effecting insurance shall void such insurance or reduce benefits unless contained in a written instrument signed by the policyholder or the insured person, a copy of which has been furnished to such policyholder or to such person or his beneficiary.

**Time Limit on Certain Defenses:** No claim for a Loss incurred or commencing after twenty-four months from the date the Insured becomes covered will be reduced or denied on the ground that an Injury or Sickness had existed prior to the Effective Date of the Insured's coverage.

**LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT**

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

**DISCLAIMER**

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member

insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do ~~not~~ not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

**NOTICE OF**
**THE ARKANSAS LIFE AND HEALTH**
**INSURANCE GUARANTY ASSOCIATION ACT**

The Arkansas Life and Health Insurance Guaranty Association Act (the "Act") provides protection, subject to certain limitations and exclusions, against loss under life and health insurance policies and annuity contracts issued by insolvent insurers licensed in this state. Some limitations and exclusions apply; some are listed below.

This notice is provided to you only to make you aware of the existence of the limited protection under the Act. It confers no rights to any policyholder or contract holder not provided under the Act. It does not change or vary any exclusion or limitation contained in the Act. Specific reference must be made to the Act to determine whether any particular policy or contract is covered, the amount of any coverage which may be available, and applicable limitations or exclusions.

Some of the limitations and exclusions are as follows:

1. The Act limits the amount the Guaranty Association is obligated to pay: The Association cannot pay more than what the insurer would owe under a policy or contract. Also, for any one insured, the Guaranty Association will pay a maximum of $300,000 no matter how many policies or contracts you have with the same insurer even if they provide different coverages. Within this overall $300,000 limit, the Association will pay a maximum of $300,000 in net cash surrender values, $300,000 in life insurance death benefits, $300,000 in present value of annuities, and $300,000 in disability or health insurance benefits. There is a $1,000,000 limit with respect to any one contract holder for unallocated annuity benefits irrespective of the number of participants in the plan.

2. You are not covered:
   a. If you are not a resident of Arkansas at the time the order of the insurer's insolvency was issued;
   b. Your insurer was not licensed in this state; or,
   c. Your insurer was a self-insured plan, trust or other similar entity, health maintenance organization or other entity excluded under the Act.

3. Obligations not specifically provided in the policy or contract are not covered by the Act. Examples of obligations, which are not covered by the Act, include damages or loss due to misrepresentations of policy benefits, inaccurate solicitation material, unfiled policy documents or endorsements, and extra-contractual damages, penalties and similar damages or claims.

4. Dividends or interest rate yields that do not meet specifications described in the Act are not covered under the Act.

**You should not rely upon coverage under the Act when buying a life or health insurance policy or selecting an insurer, and neither agents nor insurers should use the existence of the Guaranty Association to induce you to purchase a product from them.**

For more information relative to the Act, you may contact:

The Arkansas Life and Health
Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, AR 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904

| | | | |
|---|---|---|---|
| *SERFF Tracking Number:* | *ULCC-126925423* | *State:* | *Arkansas* |
| *Filing Company:* | *The Union Labor Life Insurance Company* | *State Tracking Number:* | *47427* |
| *Company Tracking Number:* | *ULL-HIP-1010* | | |
| *TOI:* | *H14I Individual Health - Hospital Indemnity* | *Sub-TOI:* | *H14I.000 Health - Hospital Indemnity* |
| *Product Name:* | *ULL-HIP-1010* | | |
| *Project Name/Number:* | *individual supplemental hospital indemnity insurance polic/* | | |

# Supporting Document Schedules

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Satisfied - Item:** | Flesch Certification | Approved-Closed | 12/30/2010 |

**Comments:**
documents attached.

**Attachments:**
AR Certification Rule 19.pdf
ActuarialMemo HIP-1010.pdf

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Bypassed - Item:** | Application | Approved-Closed | 12/30/2010 |
| **Bypass Reason:** | The application has been attached to the form schedule section. | | |
| **Comments:** | | | |

| | | Item Status: | Status Date: |
|---|---|---|---|
| **Bypassed - Item:** | Outline of Coverage | Approved-Closed | 12/30/2010 |
| **Bypass Reason:** | Pleease refer to the General Information Section. | | |
| **Comments:** | | | |

**CERTIFICATE OF COMPLIANCE WITH ARKANSAS RULE & REGULATION 19**

**Insurer:** The Union Labor Life Insurance Company

**Form Number(s):** ULL-HIP-1010

I hereby certify that the filing above meets all applicable Arkansas requirements including the applicable requirements of Rule & Regulation 19.

Gary L. Burke

**PRESIDENT**
**THE UNION LABOR LIFE INSURANCE COMPANY**

Gary Burke

November 30, 2010
Date

*UNION LABOR LIFE INSURANCE COMPANY*

*ACTUARIAL MEMORANDUM*

Policy Form: ULL-HIP-1010 : Hospital Indemnity Plan
Policy Form: ULL-WELL-1010 : Wellness Benefit
Policy Form: ULL-AMB-1010 : Ambulance Benefit
Policy Form: ULL-SURG-1010 : Outpatient Surgery Benefit
Policy Form: ULL-CRIT-1010 : Critical Event Benefit

## *I. SCOPE AND PURPOSE*

The purpose of this memorandum is to document that the premiums bear a reasonable relationship with the benefits and to demonstrate the anticipated loss ratio meets the minimum requirement for the state. The memorandum is not intended for any other purpose.

## *II. BENEFITS*

Hospital Indemnity Plan:

The hospital indemnity plans pays an ultimate daily benefit amount plus an additional incremental amount for the first 2 days, or 3 days , or 4 days or 5 days depending on the package chosen. Daily benefit amount are sold in units of $5 dollars. The benefit amount reduces to 50% at attained age 70.

Wellness Benefit:

The wellness benefit pays a lump sum benefit for preventive visits to a health practitioner. The visits includes physical examination, vision exam, dental checkups and other preventive care examinations.

Ambulance Benefit:

The ambulance benefit pays a lump sum amount in the event of visits to the hospital by an ambulance which includes ground and air transport. This benefit is payable once per year and reduces by 50% at attained age 70.

Outpatient Surgery:

The outpatient benefit pays a daily benefit in the event of outpatient surgery. The benefit amount reduce by 50% at attained age 70.

Critical Event:
The benefit pays a lump sum in the event of a diagnosis of the following:

- Cancer
- Heart attack
- Stroke
- Paralysis
- Hospitalization due to work place accident

Each benefit can be claimed once over the lifetime of this benefit. Benefits amount reduce by 50% at age 70.

## *III. RENEWABILITY*

This product is guaranteed renewable. The company cannot deny renewal but can change rates on a class basis.

## *IV. MARKETING METHOD*

This product is marketed through direct mail and available through direct purchase on our website. Enrollment is on a guarantee issue basis.

## *V. ISSUE AGES*

18-64

## *VI. CALCULATIONS METHOD*

Premiums are based on two unisex age groups and three plan levels. The first age group is from 18 to 44 and the second group is from 45 to 64. Premiums are issue age premiums and are level throughout the life of the contract. The three plans available are:

(1) Individual – Covers the primary insured.
(2) Individual Plus One – Covers the primary insured plus one dependent (spouse or child at 100% of the primary coverage).
(3) Family Plan – Covers the primary insured plus spouse and all dependent children (at 50% of primary coverage except for the wellness benefit).

The premiums were calculated by projecting the experience over the life of the policy and tested to demonstrate compliance with the appropriate loss ratio standards.

See Exhibit A for monthly premiums.

| Mode | Modal Factor |
|---|---|
| Quarterly | 3 x Monthly |
| Semi-Annual | 6 x Monthly |
| Annual | 12 x Monthly |

Assumptions used in the projections are as follows:

**(1) Morbidity:**

**Hospital Indemnity Plan**

The claims rates were derived by analyzing the data from the U.S. department o Health and Human Services for 2008 and the utilization curves from the 2005 Milliman Health Cost Guidelines for commercial ratings.

**Wellness Benefit**

The utilization rates were from the 2005 Milliman Health Cost Guidelines for commercial ratings on preventive services, and then adjusted to reflect our distribution channel.

**Ambulance Benefit**

The claims rates were derived using data from the 2003 National Study of Ambulance Transports.

**Outpatient Benefit**

Using the data from the 2006 National Health Report on Ambulatory Surgery we derived the claims cost by age.

**Critical Event**

The claims rates were calculated using data from the following:

- 2008 US Department of Health and Human Services
- Christopher and Dana Reeves Foundation for the Paralysis Resource Foundation
- Bureau of Labor and Statistics on workplace accidents.

**(2) Mortality:**

2008 VBT Limited Mortality Table.

**(3) Persistency:**

| Policy Year | Lapse Rate |
|---|---|
| 1 | 25.0% |
| 2+ | 10.0% |

**(4) Expenses:**

1. Acquisition:

| Policy Year | % Premium |
|---|---|
| 1 | 100% |

2. Maintenance:

| Year | % Premium |
|---|---|
| All Years | 23.5% |

**(5) Earned Rate:**

Earned Rate: 5%

**(6) Statutory Reserves:**

The statutory reserves are held in accordance with Standard Valuation Law.

## *VII. AVERAGE PREMIUM*

The average annual premium is $617.34 based on our expected distribution.

## *VIII. ANTICIPATED LIFETIME LOSS RATIO*

The anticipated lifetime loss ratio is calculated as the present value of incurred claims divided by the present value of annual premiums. The discount rate used was 5%.

| Benefit | Anticipated Loss Ratio |
|---|---|
| Hospital Base Plan – 5 day incremental | 51.27% |
| Hospital Base Plan – 4 day incremental | 54.11% |
| Hospital Base Plan – 3 day incremental | 51.28% |
| Hospital Base Plan – 2 day incremental | 51.27% |
| Ambulance Benefit | 53.58% |
| Wellness Benefit | 74.49% |
| Outpatient Surgery | 53.66% |
| Critical Event | 51.14% |

Each benefit component is above the 50% statutory requirement for a guaranteed renewable product.

## *IX. ACTUARIAL CERTIFICATION*

To the best of my knowledge and judgment, this rate filing is in compliance with applicable laws of the State and Actuarial Standards of Practice No. 8, and the benefits are reasonable in relations to the proposed premiums.

Wendell Cape

Wendell Cape, FSA, MAAA

11/8/2010

Date

# Appendix A

## 5 Day Benefit - Monthly Premiums

**Individual Plan - Per $5 of daily benefit**

| HIP- Base | Age | Ultimate | Incremental | Wellness | Ambulance | Outpatient Surgery | Critical Event * |
|---|---|---|---|---|---|---|---|
| | 16 to 44 | 0.37 | 0.23 | 0.30 | 0.04 | 0.07 | 0.03 |
| | 45 to 64 | 0.74 | 0.34 | 0.40 | 0.06 | 0.18 | 0.06 |

**Individual Plus One- Per $5 of daily benefit**

| HIP- Base | Age | Ultimate | Incremental | Wellness | Ambulance | Outpatient Surgery | Critical Event * |
|---|---|---|---|---|---|---|---|
| | 16 to 44 | 0.72 | 0.45 | 0.59 | 0.08 | 0.14 | 0.06 |
| | 45 to 64 | 1.45 | 0.67 | 0.78 | 0.12 | 0.34 | 0.11 |

**Family Plan - Per $5 of daily benefit**

| HIP- Base | Age | Ultimate | Incremental | Wellness | Ambulance | Outpatient Surgery | Critical Event * |
|---|---|---|---|---|---|---|---|
| | 16 to 44 | 0.98 | 0.61 | 0.90 | 0.13 | 0.20 | 0.09 |
| | 45 to 64 | 1.73 | 0.84 | 1.10 | 0.16 | 0.40 | 0.13 |

* Lump Sum Benefit

# Appendix A

## 4 Day Benefit - Monthly Premiums

**Individual Plan - Per $5 of daily benefit**

| HIP- Base | Age | Ultimate | Incremental |
|---|---|---|---|
| | 16 to 44 | 0.37 | 0.17 |
| | 45 to 64 | 0.74 | 0.23 |

**Individual Plus One- Per $5 of daily benefit**

| HIP- Base | Age | Ultimate | Incremental |
|---|---|---|---|
| | 16 to 44 | 0.72 | 0.33 |
| | 45 to 64 | 1.45 | 0.45 |

**Family Plan - Per $5 of daily benefit**

| HIP- Base | Age | Ultimate | Incremental |
|---|---|---|---|
| | 16 to 44 | 0.98 | 0.46 |
| | 45 to 64 | 1.73 | 0.58 |

## 3 Day Benefit - Monthly Premiums

**Individual Plan - Per $5 of daily benefit**

| HIP- Base | Age | Ultimate | Incremental |
|---|---|---|---|
| | 16 to 44 | 0.37 | 0.16 |
| | 45 to 64 | 0.74 | 0.21 |

**Individual Plus One- Per $5 of daily benefit**

| HIP- Base | Age | Ultimate | Incremental |
|---|---|---|---|
| | 16 to 44 | 0.72 | 0.31 |
| | 45 to 64 | 1.45 | 0.41 |

**Family Plan - Per $5 of daily benefit**

| HIP- Base | Age | Ultimate | Incremental |
|---|---|---|---|
| | 16 to 44 | 0.98 | 0.43 |
| | 45 to 64 | 1.73 | 0.53 |

# Appendix A

## 2 Day Benefit - Monthly Premiums

**Individual Plan - Per $5 of daily benefit**

| HIP- Base | Age | Ultimate | Incremental |
|---|---|---|---|
| | 16 to 44 | 0.37 | 0.10 |
| | 45 to 64 | 0.74 | 0.13 |

**Individual Plus One- Per $5 of daily benefit**

| HIP- Base | Age | Ultimate | Incremental |
|---|---|---|---|
| | 16 to 44 | 0.72 | 0.20 |
| | 45 to 64 | 1.45 | 0.24 |

**Family Plan - Per $5 of daily benefit**

| HIP- Base | Age | Ultimate | Incremental |
|---|---|---|---|
| | 16 to 44 | 0.98 | 0.27 |
| | 45 to 64 | 1.73 | 0.32 |